DOCUMENT RESUME

ED 272 229 JC 860 410

AUTHOR	Minckley, Barbara B., Ed.
TITLE	Administration in Nursing, 1982-1992: Regional Planning for the Coming Decade. Midwest Alliance in Nursing Fall Workshop (Oklahoma City, Oklahoma, September 22-24, 1982).
INSTITUTION	Midwest Alliance in Nursing, Inc., Indianapolis, IN.
SPONS AGENCY	Kellogg Foundation, Battle Creek, Mich.
REPORT NO	ISBN-0-942146-03-4
PUB DATE	83
NOTE	131p.
PUB TYPE	Reports - Descriptive (141) -- Collected Works - Conference Proceedings (021)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	*Administration; *Administrator Education; *Leadership; Management Development; Nurses; *Nursing; *Nursing Education; Organizational Effectiveness

ABSTRACT

Focusing on issues affecting the development of nursing leadership in the Midwest, the papers in these proceedings attempt to move forward the implementation of an effective program for enhancing skills needed by nurse administrators. The proceedings contain: (1) "Regional Plan for Development of Nursing Leadership Potential 1982-92," by Rozella Schlotfeldt, which presents recommendations for enhancing the leadership potential of Midwest nurses; (2) a summary of a panel discussion of the Task Group on Nursing Leadership; (3) "Education for Nurse Administrators," by Julia Lane, which identifies the educational elements needed to prepare service administrators in nursing; (4) "Nursing Administration in a Small Rural Hospital," by Janice Doxtader, which emphasizes the need for nursing administrators to understand community organization, hospital budgeting and finance, and development of personnel; (5) "Nursing Administration in a Community Health Service," by Gertrude Hotaling, which covers the elements of nursing administration and specific problems related to the process in community health; (6) "Nursing Administration in a Health Science Center," by Gabrielle Martel, which describes changes in the setting of a health science/university hospital; (7) "Problems of Nursing Service for Which Administrative Consultation Is Commonly Sought and Suggestions for Their Resolution," by Lyndsey Stone, which suggests that organizational effectiveness be a primary concern for nurse administrators; (8) reports on caucus group discussions on the definition of effective nursing administration, the pre-service educational needs of nurse administrators, academic credit programs, and regional resources; (9) brief descriptions of collaborative programs designed by the Staff of Presbyterian Hospital (Oklahoma City, Oklahoma); and (10) a statement by the Commission on Education for Health Administration on the Development of the Western Network for Education in Health Administration. (RO)

ED272229

ADMINISTRATION IN NURSING 1982-1992

REGIONAL PLANNING FOR THE COMING DECADE

MIDWEST ALLIANCE IN NURSING

JC 860 410

FALL WORKSHOP
SEPTEMBER 1982

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
M. M. Pettengill
____
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

NURSING SERVICE NURSING EDUCATION

ADMINISTRATION IN NURSING 1982-1992

REGIONAL PLANNING FOR THE COMING DECADE

Edited by
Barbara B. Minckley, DNSc.
Executive Director
Midwest Alliance in Nursing, Inc.

Midwest Alliance in Nursing, Inc.
Room 108-BR - Indiana University
1226 W. Michigan Street
Indianapolis, Indiana 46223

Published by Midwest Alliance in Nursing, Inc.
Room 108 BR, Indiana University, 1226 West Michigan Street
Indianapolis, IN 46223. (317) 264-3255

Library of Congress Cataloging in Publication Data
Main entry under title:

Administration in Nursing, 1982-1992.

Includes bibliographical references.
1. Nursing service administration--Middle West.
2. Nursing service administration--Middle West--Planning. I. Minckley, Barbara B., 1925-
II. Midwest Alliance in Nursing. [DNLM: 1. Nursing, Supervisory--Trends--Congresses. 2. Leadership--Congresses. 3. Regional health planning--Trends--United States--Congresses. WY 105 A238 1982]
RT89.A24 1983 362.1'73'068 83-12105
ISBN 0-942146-03-4 (pbk.)

Copyright © 1983, Midwest Alliance in Nursing, Inc.

Partially supported by the W. K. Kellogg Foundation

Administration in Nursing 1982-1992: Regional Planning for the Coming Decade

PREFACE

Today, administrative skills assume unprecedented importance in effective management of health care systems. Despite legal, social, and economic obstacles, women are increasingly represented in professional roles of greater power and responsibility than in previous decades. The quality of leadership demonstrated in executive roles, however, is measured by male-oriented criteria, such as impassivity, tough-mindedness, knowledgeability, high energy level, team loyalty, and political acumen. Physical appearance, an air of confidence, and persuasive skill also play a part in the executive administrative capability.

Administrative skills are not acquired as a result of chance placement in an administrative position, a frequent occurrence in nursing. Nurses in administrative positions who are educationally prepared for these roles are in the minority.

Change is needed to foster conditions in which nurses are assigned to executive positions, and accept them, on the basis of adequate experiential and educational preparation to fulfill such positions. Administration of nursing services must become a matter of documented and appropriately staged preparation, coupled with the individual's self-knowledge that he or she is committed to developing personal aptitudes in fulfillment of successively more responsible administrative roles.

MAIN's third annual Fall Workshop entitled Administration in Nursing: 1982-1992 brought together talented nurse educators and administrators to examine the issues affecting the development of nursing leadership in the Midwest. The issues were discussed not only in the context of the present but also as they could be altered through regional collaboration in MAIN, to improve the future quality of nursing leadership in the coming decade.

Poster presentations related to the theme of administration in nursing offered new ideas for utilizing education, service, and research resources collaboratively to extend and enhance patient care services.

Central to the discussions and caucus sessions was the purpose of organizing the regional thinking of MAIN Agency Representatives and nurse leaders of the region to move toward implementing an effective program for enhancing skills needed by nurse administrators.

The program presentations and discussion are summarized in this volume not only for those who were not in attendance, but also to serve as a benchmark for nursing administration planning in the Midwest, so that in 1992, progress toward goals described in 1982 can be measured.

Marilyn Rubin, RN, PhD	Barbara B. Minckley, DNSc.
Chair, MAIN	Executive Director

ACKNOWLEDGEMENTS

We wish to express our sincere thanks for assistance in preparing and reviewing this manuscript to its several talented authors and discussants; and to MAIN's administrative secretary Vicki Johnson, and typing assistant, Elizabeth Clark.

Funding support from the W. K. Kellogg Foundation, Battle Creek, MI has helped MAIN to implement the semi-annual programs with subsequent publication of program proceedings. In this way MAIN's regional planning efforts are made available to all interested persons both within and outside the Midwest region.

The Editor

TABLE OF CONTENTS

PAGE

BIOGRAPHICAL SKETCHES OF AUTHORS

WELCOME TO OKLAHOMA CITY....1

The Honorable Patience Latting
Mayor of Oklahoma City....5

REGIONAL PLAN FOR DEVELOPMENT OF NURSING LEADERSHIP POTENTIAL 1982-92....8

Report of the MAIN Task Group on
Nursing Leadership
Rozella Schlotfeldt, PhD, Chair

PANEL DISCUSSION TASK GROUP ON NURSING LEADERSHIP....17

Patricia Diamond, RN, MS
Julia Lane, RN, PhD
Jennie McKoy, RN, MSN
Capitola Stanley, RN, MS
Delores Wolf, RN, MA
Anne Zimmerman, RN

THE DECADE AHEAD --- FOUR VIEWPOINTS AND PROJECTIONS

1. EDUCATION FOR NURSE ADMINISTRATORS....28

Julia Lane, RN, PhD
Dean, School of Nursing
Loyola University, Chicago, Illiois

2. NURSING ADMINISTRATION IN A SMALL RURAL HOPSITAL....44

Janice Doxtader, RN, BSN
Asst. Administrator, Nursing Service
Eaton Rapids Community Hospital
Eaton Rapids, Michigan

3. NURSING ADMINISTRATION IN A COMMUNITY HEALTH SERVICE....53

Gertrude Hotaling, RN, MPH
Chief of Nursing Service
State Department of Health
Oklahoma City, Oklahoma

4. NURSING ADMINISTRATION IN A HEALTH SCIENCE CENTER....60

Gabrielle Martel, RN, MS
Vice-President, Nursing
Northwestern Memorial Hospital
Chicago, Illinois

5. PROBLEMS OF NURSING SERVICE FOR WHICH ADMINISTRATIVE CONSULTATION IS COMMONLY SOUGHT: AND SUGGESTIONS FOR THEIR RESOLUTION..............................72
Lyndsey Stone, RN, BA
Vice President, Operations and Nursing
Presbyterian Hospital, Inc.; and Adjunct
Assistant Professor, University of
Oklahoma College of Nursing, Oklahoma
City, Oklahoma

REPORTS OF THE CAUCUS GROUP DISCUSSIONS............88

Caucus Group A: Define Effective Nursing Administration
Caucus Group B: Identify Knowledge and Experience Needed to Prepare Nurse Administrators
Caucus Group C: Develop Strategies to Implement Academic-credit Programs in Nursing Administration
Caucus Group D: Identify Regional Resources for Nursing Administration Development

SUMMARY STATEMENTS.................................98

Rozella M. Schlotfeldt, RN, PhD

APPENDICES

A. The solution lies in the mixing of resources. Collaboration programs designed by the staff of Presbyterian Hospital, Inc., Oklahoma City.

B. Commission on Education for Health Administration: Development of the Western Network for Education in Health Administration

MIDWEST ALLIANCE IN NURSING
FALL WORKSHOP
September 23-24, 1982
Hilton Inn West, Oklahoma City, Oklahoma

BIOGRAPHICAL SKETCHES OF THE AUTHORS

JANICE DOXTADER, BSN, Assistant Administrator, Nursing Services, Eaton Rapids Community Hospital, Eaton Rapids, Michigan. Ms. Doxtader is responsible for the overall management and direction of the Nursing Department, Physical Therapy, Medical Social Work, Dietary Services, Housekeeping and Laundry. She is a former Clinical Instructor at Lansing Community College (Michigan) where she was responsible for teaching and supervising medical nursing to professional and nursing aide students. As a member of many professional organizations, she has served in a variety of leadership roles: chairperson of the MidSouth District Hospital Nursing Administrators; member, Board of the Michigan Society of Hospital Nursing Administrators; chairperson, Southwestern Michigan Director of Nurses Council.

GERTRUDE HOTALING, MPH, RN, Chief, Nursing Services, Oklahoma State Department of Health; and Clinical Assistant Professor of Nursing, Oklahoma University College of Nursing, Oklahoma City, Oklahoma. Professional memberships include Fellow, American Public Health Association; member of Sigma Theta Tau; and active participation in other organizations. Ms. Hotaling is a popular speaker who has appeared on numerous programs concerning nursing. Her nursing leadership roles include former president of Beta Delta Chapter, Sigma Theta Tau; President, District #1, Oklahoma Nurses' Association; Secretary-Treasurer, Association of State and Territorial Directors of Nursing; member, Panel of Expert Consultants for Analysis and Planning for Improved Distribution of Nursing Personnel and Services, WICHE; and member Advisory Group for the Public/Community Health Personnel Project, American Public Health Association. In addition, Ms. Hotaling is a member of the Health Science Center Nurse Administrator's Group, and is Vice Chairperson of the Oklahoma Nursing Education Consortium.

JULIA LANE, RN, PhD, Dean and Professor, School of Nursing Loyola University, Chicago, Illinois. Dean Lane's major areas of professional interest and expertise are maternal-child health nursing, and educational administration. Honors and awards received include Distinguished Alumnae, DePaul University; Phi Delta Kappa, Loyola University of Chicago; Sigma Theta Tau; and many others. Dean Lane is an active participant in several professional organizations. Her publications include "The Dean as a Person", and "Don't Hesitate: You Have a Lot Going for You". She was a consultant for curriculum development at Lewis University School of Nursing. A sampling of papers that she has presented is "Providing for Upward Mobility in Nursing"; "Need for Baccalaureate Education for Registered Nurses"; ANA Credentialing Study; Northwestern University Staff Development 1982; and "Influence of Nursing Education on the Development of a Sense of Commitment".

GABRIELLE D. MARTEL, RN, MS, Vice-President, Nursing, Northwestern Memorial Hospital, Chicago, Illinois; Assistant Professor, Northwestern University Programs in Nursing Education; Lecturer, DePaul University College of Nursing, Chicago, Illinois. She has been an Exchange Administrator at St. Thomas Hospital in London, England. Ms. Martel's professional memberships include the ANA, NLN, American Society for Hospital Nursing Service Administrators of the AHA, and Sigma Theta Tau. She serves on the Board of Directors of Loretto Hospital; has held influential committee assignments with the American Hospital Association; is a past president of the American Society of Hospital Nursing Service Administrators; and is on the editoral board of Nursing Administration Quarterly.

ROZELLA M. SCHLOTFELDT, PhD, Professor Emeritus and Dean Emeritus, Frances Payne Bolton School of Nursing, Case Western Reserve University; Chair, MAIN Task Group on Nursing Leadership; and Project Director of MAIN's Feasibility Study, 1977-79. Dr. Schlotfeldt's distinguished career includes many honors. She is a member of Sigma Theta Tau, a Fellow of the American Academy of Nursing; recipient of several honorary doctorates, and many other awards. She has written over 100 publications for professional and scientific journals, book chapters, monographs, and research papers. Her research interests include the development of research instruments, quality of care, and MAIN's feasibility study (she was the first executive director). Dr. Schlotfeldt has served on many national advisory councils, commissions, and boards.

LYNDSEY STONE, RN, BA, Vice President, Operations and Nursing, Presbyterian Hospital, Inc.; and Adjunct Assistant Professor, The University of Oklahoma College of Nursing, Oklahoma City, Oklahoma. Mr. Stone's bachelor's degree is in Health Care Administration. He served 22 years active duty with the United States Army where he attained the rank Colonel. He is a nursing consultant to Comprehensive Health Systems, Inc. and IHP Corporation, multi-hospital management systems. His area of special interest lies in innovative recruitment and retention strategies, and is a recognized leader in this field in Oklahoma. Professional affiliations include memberships in the American Society of Nursing Service Adminstrators of the American Hospital Association and its state chapter, the Oklahoma Society for Nursing Service Administrators; and member of the Oklahoma Nurses' Association.

ADMINISTRATION IN NURSING 1982-1992: REGIONAL PLANNING FOR THE COMING DECADE

MEMBERS OF THE PROGRAM COMMITTEE

Mary Botter, Assistant Director at the University of Missouri Hospital, Columbia, Missouri;

Marlys Peterson, Vice-President for Nursing; Methodist Hospital, Madison, Wisconsin;

Ruth Barnard, Associate Professor, School of Nursing, University of Michigan, Ann Arbor, Michigan;

Johnnie Emerson, Presbyterian Hospital, Oklahoma City, Oklahoma;

Rosemary Langston, Associate Dean, Winona State University, Winona, Minnesota;

Gerri Price, Director of Nursing, State Department of Health, Columbus, OH

Mary Wakefield-Fisher, Assistant Professor, University of North Dakota, Grand Forks, ND

WELCOME TO OKLAHOMA CITY

The Honorable Patience Latting
Mayor of Oklahoma City

I am delighted to welcome you to Oklahoma City for the Midwest Alliance in Nursing's Fall Conference. We are very glad you chose Oklahoma City for your meeting, especially so that we may share our lovely September weather with you. I know, as you do, the importance of adequate health care for the people not only in the thirteen states which you represent, and in Oklahoma, but also in all the rest of the nation. Surely nothing is more important to the well-being of our people than adequate health care. And, from what I have learned of your program, the Midwest Alliance in Nursing is doing an excellent job in serving as a clearinghouse for information and education for those in the profession of nursing. The particular subject of your convention--administration in nursing--is, of course, vital because it is only through proper, efficient, and good administration that the profession itself can best carry out the duties of health care.

Pleased as we are that you are here in Oklahoma City, you must not leave without having learned something about our city. Yesterday, some of you visited our Health Science Center in Northeast Oklahoma City, and had a chance to see some of its facilities and services. We are proud of this center which includes the University Hospital, the Children's Memorial Hospital, and Presbyterian Hospital. In recent years there have been over $250,000,000 worth of improvements to the Health Sciences Center, and as you saw when you were there, there are still new buildings and public facilities going up.

We also have a very large redevelopment project going on in downtown Oklahoma City. You will see the result of improvements worth 300 million dollars of private development that have been made there over the last eight to ten years, with an additional $300 million of improvements soon to begin. So, although for a long time the land had been cleared for the development, not much happened; and I was forced to explain on many occa-

14

sions to groups visiting Oklahoma City, that we had not cleared that land in downtown Oklahoma City just to plant a stand of corn. Clearing the land was the beginning of the project which is just now coming to fruition. There is a tunnel system beneath downtown Oklahoma City which connects most of the office buildings, stores, and facilities in the downtown area. Unlike Minneapolis where the walkways are above ground, here in downtown Oklahoma City most of our connecting facilities are underground.

People are friendly in Oklahoma City. It is a city of neighborhoods. At last count there were 140 neighborhood organizations which link the people together in various areas of Oklahoma City. We think we have the advantages of both a large city and a small town because of these neighborhoods, and the close ties among those who live in them. They get to know one another as they work together for the improvement of their part of the community.

The National Cowboy Hall of Fame, located in the Western Heritage Center has one of the finest collections of western art in the country including many Remingtons, Russells, and a very interesting display of the western trails that opened the west for settlement. We have a ballet company, a symphony orchestra, a theater center which, incidently, is now presenting "Oklahoma" in honor of the seventy-fifth anniversary of Oklahoma statehood. Many people, when they think of Oklahoma, think only of the country humorist Will Rogers, and the musical production of "Oklahoma", and while we are very proud of both of them, we also have several fine art centers. We have reknowned sports teams, as you know. Our new soccer team, the Slickers, lost to Detroit - (those of you from Michigan I welcome you anyway).

Oklahoma City has a unique history. The city was born in one day on April 22, 1889. On that day at high noon in 1889 a rifle shot cracked, signalling to thousands of people waiting at the restraining line to come to Oklahoma Territory to claim land for homesteading. The Homestead Act allowed them to build a new life for themselves and their families. They came on horseback, they drove buggies, they drove wagons, they ran, they walked, and some came on the railroads as far as the line would take them. By nightfall on April 22, 1889 Oklahoma City, had a population of some 10,000 people. On that day Oklahoma City was born, and since that time it has grown until today it has a population of 408,000 in the metropolitan area, and some 850-860,000 in the greater city area which now includes 621 square miles. In 1989, just seven short years away, the city will celebrate its centennial.

One of the consequences of the city's rapid expansion has been that the tax base has not eroded as it has in other communities where people have moved away from the more densely populated central city to another jurisdiction. Here, people may move ten, fifteen, even twenty miles away from downtown and still be in areas with five acre locations for homesites within the city limits. At the same time, within these 621 square miles, we grow more wheat than any other city in the world! We have been fortunate in other ways too. Our unemployment rate in Oklahoma City traditionally runs three or four points below the national average. Our primary industries are agriculture and energy, particularly oil and gas, but some coal in the southeastern part of the state. Although we are beginning to feel the recession, which of course is inevitable, we hope that, as in years past, it will not go to the depths that it has in some parts of the country. So let me welcome you to the city that we think combines the best in rural and urban living. We hope you enjoy being here and that you will come again soon.

Report, Recommendations, and Discussion of the MAIN Task Force on Nursing Leadership

Rozella M. Schlotfeldt, RN, PhD

The Task Force

My first trip to Oklahoma City in 1978 was a very enjoyable one, at the time of MAIN's feasibility study. It is exciting to return now when MAIN is well established and its activities ongoing. In the next thirty minutes I shall present the task force's regional plan for enhancing the leadership potential for those midwest nurses who wish to avail themselves of educational opportunities in order to develop their leadership potential.

In my view, the Midwest has the largest tank of latent nursing leadership talent in the whole country. Some of it has already been developed and, as we all know, we have some outstanding nurses who are giving remarkable national and international leadership. But there is, in addition, another group of persons who have latent talent-talent that is ready to be developed if nurses could avail themselves of opportunities made more readily accessible.

Secondly, circumstances existing in 1982 and other changes certain to be forthcoming in the next decade are going to take every bit of leadership talent that nurses can muster. Nursing must have the necessary leadership for fulfilling its social mandate to meet the nursing needs of citizens throughout the midwest, and beyond.

In 1981, MAIN's Board appointed a task group on nursing leadership to prepare a regional plan for development of the leadership capacity of nurses in the Midwest. The plan was to encompass predicted needs for nurse leadership education for the next decade. The task force members were:

Pat Diamond, Vice-President for Nursing, Hutchinson Hospital, Hutchinson, Kansas, and immediate past Chair of the MAIN Governing Board.

Jenny McKoy, Chief Nurse, Veterans Administration Medical Center, Hines, Illinois.

Capitola Stanley, Director of Nursing, McLean County Health Department, Normal, Illinois.

Delores Wolfe, Director of Nursing, Ellsworth Memorial Hospital, Iowa Falla, Iowa.

Anne Zimmerman, Distinguished Professor, Niehaus Chair of Nursing, Loyola University, Chicago, Illinois.

Julia Lane, Professor and Dean of the School of Nursing, Loyola University, Chicago, Illinois.

Note that these task force appointees represented large and small hospitals, community hospitals, large hospital teaching centers, (both education and service), and community health agencies. It is characteristic of MAIN committees and work groups that all types of agencies are represented. The task force met two times in the year of its existence to develop a region-wide plan. In addition to the two meetings, members communicated by letter. Briefly we examined the notion of documenting both the need for and the demand for educational preparation for administration by nurses in the midwest region. We decided, however, not to waste time and money in documenting conditions already so well known. We all know that nurses have succumbed to pressure to accept administrative positions for which they are not academically prepared. Despite the fact that many have given heroic effort just to hold nursing service and nursing educational programs together, leadership without benefit of appropriate training cannot be as effective as it should be now; and certainly will not be in the future.

We also know that statements of respondents' *interest* on survey forms are not necessarily equivalent to statements of *demand*; and, therefore, the task force did not survey the region in an attempt to document interest in, or demand for educational programs in nursing administration.

We also know that some sections of the midwest lack educational programs in nursing administration and that there are nurses in these underserved areas who would like to enroll to obtain advanced preparation. At the same time even in metropolitan centers of the midwest there are too few prepared educators available to provide educational programs in nursing administration. They tend to be concentrated in certain places.

The Charge to the Task Force

The challenge, therefore, to the task force members was to:

1) devise a plan through which we could augment educational opportunities for preparing nurse administrators;

2) make wise and productive use of the talents of faculties prepared to offer those educational opportunities;

3) market the opportunities appropriately so that persons seeking such opportunities would know where they are and how best to obtain them; and

4) obtain, if at all possible, some financial assistance to make it possible for MAIN, as a sponsoring regional organization, to serve as a broker in order to facilitate the regional plan.

The group unanimously agreed that MAIN should promote sound academic education for degree credit rather than short term continuing education programs, although the latter should always remain an option. Since the task force took the long range approach toward upgrading qualifications of nurses for leadership, and more particularly administrative leaderhsip, its members support the idea of preparing persons in programs of study offering degree credit. Administration was seen as both a science and an art, and nursing as a consequential professional service.

Programs currently available

Thus, the midwest regional plan endorses making sound education in administration available for credit toward an academic degree. Our emphasis was initially on graduate credit, but that is not to deny the fact that increased opportunities are needed for persons to achieve undergraduate education; that is, first professional degree education in nursing in which leadership preparation is an integral part. The task force made note of several facts.

First, there is an increasing number of graduate programs in nursing throughout the region at both master and doctoral levels. We are already moving rapidly to increase educational opportunities for nurses throughout the midwest.

Secondly, we are augmenting the number of programs offering nursing administration as majors and as minors in masters programs, post-masters programs, and as integral parts of doctoral study.

Thirdly, certain higher education institutions have offered various kinds of educational programs in administration on extended campuses, and in various kinds of corporate endeavors. For example, the University of Illinois and the American Hospital Association cooperated in offering and marketing educational opportunities in administration available through the University of Illinois. Wayne State has offered a very successful program in administration on an extended campus, at post-masters level. The Wayne State campus was extended to a site in northern Indiana, and provided opportunities for nurses from Michigan, Ohio, Indiana, and Illinois with opportunities to earn predoctoral academic credit. The program allowed concentrated periods of course work on Saturdays and Sundays periodically throughout a semester -- an attractice feature of the program to working nurse administrators.

Fourth, the University of Minnesota's School of Public Health offers an extensive program of study in administration with workshops, home study, and some on-campus (Minneapolis) learning opportunities provided. On successful completion, this program leads to a certificate rather than academic credit. These four illustrations indicate to you that educational institutions are interested in providing additional opportunities to prepare nurse administrators.

Task Force Assumptions

It was the belief of task force members that each learner should have the benefit of sustained academic advisement; and that the integrity of academic programs should be meticulously respected. We recognized that program requirements at the University of Oklahoma, for example, might be at variance with program requirements at Wayne State or the University of Illinois. Nonetheless, the task force members believed that there is an essential core of content in administration that could be agreed upon. There should be consensus about what constitutes that core content for advanced preparation in administration.

We thought it appropriate to ask program directors who offer such programs to address that question, and to come to some conclusion about what is the essence of advanced preparation in administration that should be an integral part of all programs. The objective is to agree upon a set of learning opportunities, whether courses or practice, that would be acceptable in all programs. Just as an example I suggest that we could all agree that financial management and budgetary planning and control are integral parts of all programs in administration. There is little disagreement about that statement. Similarly, we could agree that personnel management and labor relations also represent essential content. Undoubtedly, basic content in administrative science could also be identified. Without speculating further, it appears evident that program directors should give attention to these recommendations, and should come to some agreement about essential content for nursing administration.

Turning to the question of making study more accessible, the task force members agreed that it might be possible to offer concentrated course work during summers, perhaps on weekends, or other times during the year, such as intersession breaks in some institutions and in some geographic locales. This would make learning opportunities relatively more accessible to those nurses who had previously have not had such opportunities, but who are committed to obtaining them.

Recommendations

The task group maintained that aspiring nurse administrators should enroll in an advanced program of study, with true commitment to qualify for a graduate academic degree. Enrollment in the academic program would ensure that the student would receive sustained academic advisement relative to planning a total program of study to be pursued in a reasonable sequence.

To make this type of academic education relatively cost effective, the task group advised sharing the talents of faculty who teach content in administration, and who may be currently teaching relatively small numbers of students. A new program often attracts very small numbers of students initially until that program can build up. In this regard, the task group supports development of extended campuses - such as that of the Wayne State University College of Nursing.

A second recommendation is that well-qualified visiting or adjunct faculty, who may already be teaching in established programs of study, be appointed to several different Universities' faculties, who would all be participants in the extended campus program. For example, this summer I had a marvelous experience at the University of Texas at Austin, I was appointed as a visiting professor. So, also, was Jessie Scott from the University of Maryland and Frank McLaughlin whose home base is California State University. Students from all over the country came to Texas and enrolled in courses taught by those visiting professors who came from all over the country and were given appointments at the University of Texas.

Now what we are really proposing is that well-qualified midwestern faculty members, some in Schools of Nursing, some in Schools of Business, some in Economics, some in Schools of Management, experts in their respective fields of administration, finance, etc., offer programs of study that represent this core of Administration content for which students would earn credit in programs in which they are matriculated.

For example, the extended campus might be in Kansas. Students enrolled would learn from Oklahoma professors, from North Dakota professors, or from Michigan professors; but they would all earn credit which would fulfill degree requirements in the Universities in which they are matriculated. We know that there are many excellent faculty who hold appointments in those several universities. Some might come to Oklahoma and teach for a summer term while others in Oklahoma might like to teach the summer term in northern Wisconsin, Minnesota, Michigan, or Ohio. In any case, visiting faculty can make programs of study in administration more accessible to nurses in the midwest. Students, whether they are enrolled in public or private institutions, would receive credit in their home schools where their tutition is paid. They would only be taking some of their course work on an extended campus away from home. Such a plan would make it possible for faculties to reach more students, and to have experiences in teaching on such an extended campus.

We have pointed out that some graduate programs now offer clinical nursing without giving students the option of enrolling for additional work in administration. Many who offer those programs in clinical nursing specialization would like to offer additional work in administation, but simply cannot afford to add a professor at this time of economic constraint. This plan would make it possible for their faculty to give sanction to an administrative option and to appoint some visiting professors to teach it.

An additional point to be emphasized is that throughout this great Midwest we have some very famous and very able administrators both in schools of nursing and in nursing service agencies -- small and large community agencies, acute care settings, and long-term care settings. These administrators, we believe, could also be enlisted to offer residencies or practica of several kinds, and thus to share their talent with the students enrolled in this extended campus plan. This could be arranged at the convenience of students and their mentors.

With the plan as proposed, the integrity of programs is not lost and student advisement is sustained at the student's home base. The education is sound and leads to academic credit. Faculty talents are conserved and shared. Increased number of nurses could be enrolled in these off-campus or extended campus courses. Money would be saved by concentrating class time to reduce travel costs and by sharing faculty. In addition, a significant contribution would be made toward the goal of having qualified nurse leadership in many institutions that now are not so privileged.

We think that this plan, which we believe does not exist any place else, could likely be sold to a risk-taking Foundation for a specific time period in order to demonstrate its effectiveness and success in the region. We believe that definite goals should be established and that the program should be region-wide, brokered by MAIN. The program ideally would have the positive sanction of all the Midwestern higher educational institutions now offering nursing programs, and by those seeking to have advanced preparation in nursing administration.

Proposed Program Goals

Several goals are suggested:

1) to augment the total number of prepared nurse administrators in the midwest by a certain number in the next decade, and to work definitively toward attaining that goal;

2) to upgrade the qualifications required for nursing administrators in specific service and educational institutions, in specific states, or throughout the midwest, and to augment the number of prepared administrators by a specific number, -- in small institutions, mid-sized institutions, large institutions, city institutions, and rural institutions, within a stated time period;

3) to extend the educational opportunities for nurses in the midwest by augmenting the number of majors and minors in nursing administration available to them, by a stated number within the next decade; and

4) to demonstrate the cost effectiveness of this concept of extended campuses and adjunct or visiting professors during the next decade.

Although this was not discussed by the task force, the concept of traveling professors is a useful strategy. Faculty who have sabbatical leaves might well design a very effective program in administration to share their talents across the region. That is the essence of the task force's recommendations for regional development of nursing leadership.

Published by Midwest Alliance in Nursing, Inc.
Room 108 BR, Indiana University, 1226 West Michigan Street
Indianapolis, IN 46223. (317) 264-3255

Library of Congress Cataloging in Publication Data
Main entry under title:

Administration in Nursing, 1982-1992.

Includes bibliographical references.
1. Nursing service administration--Middle West.
2. Nursing service administration--Middle West--Planning. I. Minckley, Barbara B., 1925-
II. Midwest Alliance in Nursing. [DNLM: 1. Nursing, Supervisory--Trends--Congresses. 2. Leadership--Congresses. 3. Regional health planning--Trends--United States--Congresses. WY 105 A238 1982]
RT89.A24 1983 362.1'73'068 83-12105
ISBN 0-942146-03-4 (pbk.)

Copyright © 1983, Midwest Alliance in Nursing, Inc.

Partially supported by the W. K. Kellogg Foundation

Discussion

Moderator

At this time the panel of task force members and Dr. Schlotfeldt are available for questions or comments in response to this presentation.

Question

I have two questions. One is: How can the program be self-supporting if the tuition and other fees go back to the original school? The other question is: Would you expand on your statements regarding the issue of a major and/or an option?

Dr. Schlotfeldt:

Those are very good questions. So far as tuition is concerned --when one pays tuition now to an educational institution, at least in part, that tuition is used to support the professors who teach the courses. If they are courses offered by several institutions, obviously tuition income ought to support the professors. I am suggesting that initially, since it is a risk capital venture, we might find some funds to support its inception. Eventually, the program should be self-supporting. Indeed, I would think that the program now being offered by Wayne State University College of Nursing could be used as a model. It is self-supporting and that is the way it is designed to be.

We know that tuition does not fully support educational programs. Various institutions use other sources of support. Certainly an equitable plan could be developed whereby the tuition from students enrolled in one institution could help defray costs of courses taken by that student in another cooperating institution. Initial costs would be high for travel, setting up arrangements, and so forth. It is a program that requires time, effort, and resources to get it off the ground; but if it is successful, it certainly should be self-supporting.

In response to your second question, let me say that the task force members believe very strongly in the integrity of programs. Some programs offer residencies;

others offer practica. Some have practica as integral parts of their program of study. Some offer majors, other offer minors. We are suggesting that the program selected, is the choice of the candidate. Therefore, the candidate would fulfill whatever requirements are set forth by the institution offering the program. So, if a residency was not offered in a given program, the student involved would not need to take it.

J. McKoy:

The issue of the integrity of programming is a very important one, one we need to evaluate carefully. My concern, as a nursing service administrator, was that the current programming which provides advanced clinical preparation is not necessarily the program that meets the needs of a nursing service administrator. I think we need a program dedicated to nursing service administration. That is, I think we need an administrative program, not an administrative track within a clinical program.

In my hospital, and possibly in most of yours, it would be very difficult for me to decide in which area I should become a clinical expert. And, the fact that I very seldom get a chance to interact personally with patients makes it even less important to me. So, I am quite sure that some of you will share my concerns that education cannot abdicate its responsibility to develop the administrative abilities of potential nursing service administrators, by farming them out on a practicum with some busy nursing service administrator to do the job. We have to have faculty within the educational program who are highly qualified teachers of nursing service administration. Educational content needs to focus on learning to use power, and to recognize and counteract abuses of power; learning to negotiate; learning to manage resources and how to compete for dwindling resources. We have to learn all those things, for which there are teachable strategies and techniques. If nursing education does not begin to address these concerns, more and more nurses will go to graduate schools of health service administration for their degrees. In the *Journal of Nursing Administration* you will note that many of the ads for positions available now are specifying masters in nursing, or business administration, or hospital administration. If we are not able to prepare nurse administrators, it will get away from us entirely.

Comments:

I have said for many years that I believe we do need to teach nursing service administration in the realm of nursing. One of the reasons that I agree with emphasis on nursing administration rather than the clinical area is exactly what Jenny McKoy has said said. However, I do recognize that when the nurse executive officer is appointed to an institution of 150 beds or less, that person may very well need all the clinical expertise she can get. But, when you start talking about institutions larger than that you have the ability to go to the specialist in those areas and to ask them what they need, why they need it, and then to become more knowledgeble in these particular areas. So, I do agree with Jenny on that. I would like to bring up one other point. Having been one of the original founders of a graduate council for education in administration in nursing, I would like to point out that that particular group has identified the various cores that are necessary at the graduate level. You will find them published over the years in the Journal of Nursing Administration.

Question:

I have a question particularly about the issue of accessibility. You originally mentioned that nurses would be in a home institution or have a primary institution in which they would be enrolled in a graduate program and then also have the accessibility to join other programs to move to topics that they were interested in. Would we truly be able to keep the nurses employed in their current job and also go to school at the same time? One of the disadvantages I have seen with many of the programs is that you really need to get out of service and go into education for a year or two before you can complete the graduate training that you are interested in, and then go back into service. Did your committee address that issue of accessibility while the administrator is maintaining employment?

Answer:

If you look at the data coming from the American Association of Colleges of Nursing you will see that many of the graduate programs are offered on a parttime basis. We envisioned a regional program like this because people who are able to move in nursing service have full-time responsibilities. This is therefore planned to be a program, as Rozella said, that would be offered on weekends, part-time, in intersessions, in blocks of activities. It was not planned to require two years out for full-time graduate study.

Question:

I don't know whether your committee considered this, but in terms of an administrative program or track that you might offer, did you consider in the proposed model an interdisciplinary way of educating nurses rather than educating them in isolation from other disciplines?

R. Schlotfeldt:

I think I suggested that the faculty -- let's say for a summer term -- might include professors of economics, professors of finance, professors of nursing administration and so on, and therefore be interdisciplinary in that sense. If the question was, were we concerned with interdisciplinary education that would offer administrative training for persons who are not nurses, the answer is no, our committee did not address that. That wasn't our charge nor is it necessarily something that MAIN would be expected to sponsor. We are interested in providing opportunities for nurses. There are great advantages to having persons take courses and rub elbows with persons in other disciplines, but that was not a part of our charge.

MAIN is not an educational institution. MAIN cannot offer academic programs. Academic programs belong to higher education institutions. Therefore, if a nurse wants to enroll part-time in this program, there is nothing to preclude her from taking courses elsewhere that would allow her to rub elbows with persons who represent other fields of work -- administration in business, administration in hospitals, or the like. One's whole program is necessarily not the weekend program. It may well be only a part of it.

Question:

But I guess I hear a need to develop stronger administrators and if our past or traditional ways of educating nurse administrators hasn't been all that effective, particularly in terms of staying in their positions over long periods of time, my suggestion is that an interdisciplinary way of educating nurses might help them to be more competitive with other administrative personnel within the system.

R. Schlotfeldt:

I certainly think your point is well taken. I think this program was not intended to solve all problems, but to address quite a few of them.

Question:

Some panelists want to see expansion of graduate programs with content totally devoted to nursing service administration, while other members of the panel appear not to agree. Can you clarify the panel's differences on this point?

J. McKoy: (Task Force member)

The task force report said that there should be continued emphasis on the clinical nursing component at the graduate level. I disagreed with that. I agree that we need interaction with other disciplines who are involved in managing resources and health care. In my job, I have clinical experts to deal with the clinical nursing matters. I cannot be a clinical expert to all my patients. What I do need to know is how to interact at the executive level to get an adequate share of resources for delivery of quality nursing services to patients. We have fine educational programs that turn out clinically prepared nurses. If we try to tack on nursing administration in addition, the result is not what we need in preparation for nursing administration. Once begun, I think it is very difficult to turn educational programming around. I got my masters in administration many years ago. We learned administration in other schools, brought it back to the nursing realm, and applied it to nursing. The title "nursing administration" is misleading, administration is administration. Just as "nursing research" is a misnomer. Research is research, whether it is done by nurses, done by physicians, social workers, or others. My concern is that if we try to tack administration content on to the clinical specialist track, because there is too little time in any program for both, we prepare neither administrators nor clinical specialists.

Question:

I agree wholeheartedly that clinical preparation does not prepare one for administrative posts. I disagree that clinical preparation is not important to the administration of nursing services. I disagree also that there is no such thing as nursing administration. I feel very strongly that there is, without taking up time to go into that now. However, there is another very important dimension that I hope the task force has included among those areas that should be targeted for preparation and that has to do with politics in nursing. I think that perhaps that is the thing that requires nursing administrators to have a strong clinical background, because in applying the administrative and managerial concepts, one has to be fully aware of the politics in the field, and also of those things that are unique to this particular practice that may not apply across the board.

Answer:

I want to speak for nursing service in small hospitals in the rural areas -- a great concern for all of us. I represent a 200 bed hospital in a city of 50,000 in rural Kansas. It is not nearly as rural as most of the hospitals in Kansas, and perhaps throughout the midwest, in that we have more hospitals with less than 100 beds than we have with more. Now, obviously, we need leadership in these small hospitals as well as in the larger hospitals. Perhaps many of you nurse administrators have experienced a reaction as I did recently when discussing a patient nursing problem with a physician who said to me: "Oh that's right, you used to be a nurse, didn't you. That says to us that we need leadership in administration, with an emphasis on nursing. The only patient advocate left is the nurse; so if we are really concerned about patient care then we need nursing leadership to provide it. It does not necessarily mean that we must do "hands-on" nursing to demonstrate clinical skill, but rather it means that you have to understand what nursing is all about today to be able to give the right type of nursing leadership. Now, obviously, small hospital needs will be different from those of larger hospitals.

I support the recommendations of the task force, and believe we need to set high goals. I agree that we need to set qualifications for nursing leadership and press toward reaching that. Because of the large number of nurse administrators without baccalaureate educational preparation, we may need an interim period to move those nurses who are motivated to be eligible for graduate education. This does not mean we should not set the goal, or support the recommendations of the task force. I would hope that after you hear the papers today that you could envision MAIN as setting up a model for the region -- a nation-wide model for nursing leadership in large or small hospitals; and that there is also an inherent clinical component.

R. Schlotfeldt:

I would like to emphasize that this is a workshop, and that the members of the task force believed it would be presumptuous of them to come up with a curriculum, or even a set of courses. Curriculum and course planning are the prerogatives of persons who are the educators, the experts. And, it is for that reason that I emphasized our respect for the integrity of educational programs. I would like to observe that there are, at the present time, some majors in administration, most particularly nursing service administration. Obviously there are different points of view and differences in program requirements. I tried to make very clear that the task force members believe that we should respect the integrity of programs and the wisdom of faculties who offer those programs; so, therefore, we are not suggesting program requirements. We are suggesting a mechanism, and I hope we might have some discussion on what you think of the idea. Do you think we could make it work? Do you think we have enough talent in the midwest to make it fly? That is the kind of thing I think we ought to be discussing right now.

Question:

I was a participant in the Wayne State Program, and I would like to say that I am wholeheartedly in support of what you are trying to propose. As a student in the Wayne State Program I carried twelve to fifteen credit hours while working full-time. The Wayne State Program was excellent, but probably due to the drain on my energy level, I was not able to complete it. Even so, I still believed that I needed something to continue to do my job in administration. By word of mouth from people who had taken courses, I heard about the University of Minnesota Independent Study Program (ISP) in Patient Care Administration (PCA), and that program entails exactly what the task force is trying to do. Part of the program does address the issue of interdisciplinary exchanges because it has a segment for hospital administrators, mental health, nutritionists, and so on. In any case, the program is based upon concepts similar to MAIN's task force on nursing leadership. One of the things that I think that we might have to think about with MAIN is selectivity in relation to nursing. By being selective we are also limiting our population. The Minnesota program is successful because it addresses all populations. In fact, people come from every state of the union and beyond. It is a very well known program. One economical consideration is the regional limit because of MAIN. I can see why we might need some guidelines to serve our thirteen states, but one of the things that I think of when we are trying to make this much-needed program feasible is whether we would have some economic problems because we are trying to draw from too small and too select group. It takes a large financial base to support such programs. Even so, I support what you are trying to do, and I do think it addresses a major nursing need.

Answer:

I would clarify that the previous speaker was not a a student in our post-master's, extended campus program in administration, but in the masters program. These are two very different kinds of programs and I wanted to make that clear. I speak strongly in favor of attention to the content that is being administered and not only the process of administration. I am concerned that nurse administrators may become so far removed from nursing that they no longer have within them a valid philosophy of advanced practice which they should be promoting in the practice setting. Medical directors, no matter how well trained they may be in terms of management, are always there fighting for medical practice, demanding the kind of support that is necessary for good medical practice. In contrast I have observed nurse administrators not fighting for nursing practice, but responding with behaviors and attitudes more like an assistant hospital administrator than a nurse. In many instances, I can't tell the director of nursing from an assistant hospital administrator. I think if the nursing service director has not been professionally prepared in advanced practice then she is not so inclined to fight for nursing practice principles and goals. When this happens the end result is nursing practice at a level which focuses on hygiene of the patient, and carrying out the physician's orders.

I believe the nurse administrator must know what good patient care is, as well as how to get the resources to support staff in delivering that care. Neither one alone is enough. You must have both. In Detroit we have seen the problems of the automobile industry when they filled management positions with people who were experts in management but didn't know very much about automobile design or manufacturing. And, now, all of these problems in the auto industry are coming home to roost because each management expert was operating from the bottom time, given three years in which to make a reputation, and didn't take the long-term view that a professional who was well groomed in the field probably would have. You alluded earlier to nursing research. Fifteen years ago when we prepared our researchers in the basic disciplines in the Nurse Scientist programs nurses received good research training, but were doing psychology's research, sociology's research, anthropology's research. In most instances they were not doing nursing research -- not asking the nursing questions -- because many of those nurse scientists had been away from their own discipline too long to be well groomed in the practice questions that needed to be asked.

Many nursing students today are coming for their masters degree at twenty-three or twenty-four years of age, and at that age and in that masters program it is not possible to prepare an executive level leader. I believe she should be well-prepared as an advanced clinical specialist, so that she knows practice, knows what her goals are, and has developed the philosophy. Then make the administration courses available to her on a part-time basis so that she can get on with her career, but do these things within a framework that is possible for her. I also do not believe that all the courses should be taught by nursing. I think we should bring managers from the School of Business Administration. We need accountants to teach accounting, but the program needs to be controlled and coordinated by nursing faculty who know what the long-term nursing goal is.

Question:

Well then, you're not suggesting an administration track in a clinical specialist program, are you?

Answer:

I don't think it's possible -- my theory is that it's not possible to include it in the masters program. Our position is to take a minor in the masters program -- I might say as long as I've got the podium, when we started our program we had some federal funding for an advisory committee. I got counsel from a lot of people and selected two or three people whom people told me were outstanding administrators in nursing service in hospitals. I had two who were outstanding administrators in community health, two who were outstanding administrators in professional membership organizations, and two who were outstanding in educational facilities. This Advisory Committee met with us over a period of several years and overwhelmingly agreed that the program should be offered at postmasters level. The masters degree was needed first, and then the immersion in administrative content. I agree that these courses should be for credit toward degrees or academic credit. Ours is a one year postmasters program which is integrated with the PhD program so that students can go on into doctoral study. It articulates in that it provides closure after one year postmasters if they wish to terminate at that point. But, I do not think, in any masters program, you can prepare an individual adequately for executive level management, either in nursing or in management.

Answer:

I wholeheartedly concur. Thank you.

Question:

I assume the papers yet to be presented will give us that information about how programs are organized? When we talk about strategies, this group might decide not to support a student who goes into a program with a minor in administration and a clinical track.

EDUCATION FOR NURSING SERVICE ADMINISTRATION

Julia Lane, PhD

Over the last ten years the issue of education for nursing administration has been addressed in four regional conferences at the Universities of Michigan, Arizona, Minnesota, and Boston. Consensus about what comprises optional educational programs for nursing service administration has not been achieved at these conferences. However, some assumptions from these groups could be accepted as a starting point for discussion. These are that:

1. The nursing administrator's primary responsibility is to give leadership to the nursing staff in providing quality patient care (Leininger, 1974; Brown, 1979).
2. The nursing administrator operates for the most part in two cultural sub-systems; nursing and administration.
3. The size and complexity of nursing service organization and the politicalization of the health field requires the nursing administrator to have knowledge of a variety of disciplines.
4. The work force for whom the nursing administrator is responsible comes with a diversity of educational preparations and competencies. It is predominantly female and the majority of workers have dual responsibilities for home and profession which inhibit commitment and responsibility for the demands of around-the-clock nursing care (McClure, 1979).

These assumptions provide a foundation for identifying the educational elements needed to prepare service administrators.

I. A Model for Planning for the Education of Nurse Administrators

In a classic article Katz (1974) suggests that "effective administration skills rest on three basic personal skills." By "skills" he means the ability to translate knowledge into action. These are identified as technical skills, human skills, and conceptual skills. These skills can be developed through innate ability, education, experience, and affective mentoring. This "model of skills" is used as a structure upon which to design an educational program for nursing service administrators. The meaning of these skills has been developed by Katz as follows:

1. Technical Skills

As used by Katz, technical skills means an understanding of, and proficiency in, specific activities.

Technical skills involve "specialized knowledge, analytical ability within that specialty and facility in the use of the tools and techniques of the specific discipline" (Katz, 1974, p. 90). When the administrator has technical skills, he is able to ask the right questions of his subordinates as well as to evaluate the answer. In nursing we would probably prefer to call these skills "professional" but the generic term "technical" is also appropriate. Katz illustrates technical skills by using the analogy of a surgeon's skills.

2. Human Skills

This is the executive's ability to work as a group member as well as a leader to build cooperative efforts with the team to achieve the goals of the organization. "This skill is demonstrated in the way the individual perceives (and recognizes the perception of) his superiors, equals and subordinates, and in the way he behaves subsequently" (Katz, 1974, p. 91).

3. Conceptual Skills

These are the ability to think in terms of "relative emphasis and priorities among conflicting objectives and criteria; relative tendencies and probabilities (rather than certainties); and rough correlations and patterns rather than cause and effect relationships". This is the skill essential for the chief executive officer who must be able to recognize conflicts and accept solutions that may be adequate and feasible rather than optimum.

Katz says these three skills - technical, human, and conceptual are so closely interrelated that it is difficult to know where one ends and another begins. All three skills are important at every level of administration but their relative importance is dependent on the level of responsibility (Katz, 1974, p. 94).

Let us look at these three skills in light of the first three assumptions and see how this will help us determine the knowledge needed to educate nursing service administrators. Recall that:

1. Nursing administrators' primary responsibility is to give leadership to nursing.
2. Nursing administration operates in sub-systems; nursing and administration.
3. Nursing administration requires the management of a large complex organization.

1) Technical Skills in Nursing

It is obvious from the assumptions that there are two major categories of technical skills required, those related to nursing and those to administration.

For the nursing administrator the discipline in which understanding and proficiency is demanded is *nursing*. Thus the administrator must possess a direct knowledge of today's nursing practice, and understanding of the goals of the profession, an appreciation of the educational competencies of staff, a knowledge of nursing and role theory, and skills in research. Because nursing is also in the sub-system of administration, the nurse administrator must have knowledge of the principles of administration, organizational systems, and the effective use of power. The nurse administrator must have some facility in understanding methods of budgetary and quality control, staffing, legal aspects of health care delivery, and labor relations.

In developing an educational program for nursing administration students, the question most debated is: Does a student in nursing service administration need additional knowledge and clinical experience in nursing?

It is my belief that without the additional technical skills obtained in a clinical nursing practicum during the graduate experience, the nursing administrator will be unable to achieve the identification with nursing staff which facilitates leadership and the development of a power base which springs from perceived competence in the discipline. The practicum is not an effort to direct the administrative student to clinical specialization but to have her re-process current nursing practice in the light of administration.

2) Human Skills in Nursing

Both nursing and administration demand human skills. It is essential for the nursing administrator to have the leadership skills, the self awareness, and the sensitivity to maximize the capabilities of the patient care staff and to appreciate the intra-group dynamics of workers (Brown, 1979; McClure, 1979, and Poulin, 1979).

Essentially leadership is comprised of inter-relationships among the leader, his followers, their organization, and their milieu (McGregor, 1966). Human skills in leadership include communicating, motivating, selecting, and developing people as well as decision-making, all of which flow from a personal philosophy of life and an underlying value system.

The foundation for human skills is rooted in the disciplines of philosophy, sociology, anthropology, psychology and even theology. The candidates for administration majors should have a strong liberal arts component at the bachelor degree level. These skills are enhanced by knowledge about human engineering, the developmental needs of adults, intra-group process skills, and the theories of learning, motivation, change, role, and communication.

Human skills are necessary at every level of administration but as the horizons of responsibility widen, there is a change in the focus of these skills, from intra-group to inter-group. The chief executive is concerned mostly with the dynamics between groups as priorities are established.

3) Conceptual Skills

The ability to see the big picture is a skill that is essential to overall planning, policy making, and broad scale action. Visualizing scenarios of contextual relationships as they could effect the organization is the primary responsibility of the effective executive. This skill of conceptualization is probably not learned in the classroom -- in fact it may not be learned but may be an innate capability like music aptitude (Katz, 1974). The ability to conceptualize is a creative and intuitive process and includes analytical dimensions. As a rule conceptualization does not come easily to nursing faculty or nursing students, because of the pragmatic education typically found in nursing.

Conceptualization can be fostered in an apprentice administrator by appropriate mentoring, progressive and diversified asignments, and case problem analyses. Emphasis on theory, concept development, and research skills in the graduate nursing curriculum can be helpful.

Conceptualization, for nursing service administrator, involves the ability to interrelate all parts of the health care delivery system toward effective patient care. It also demands the ability to set objectives for the organization as a whole and move the collective organizational effort toward achievement of these ends. Conceptualization in nursing service administration involves the ability to develop organizational structures that will maximize the potential of others, finding competent personnel to actualize these structures. It involves forecasting based on trend analysis, and getting the most return for the least investment of resources.

Because the three skills -- technical, human, and conceptual -- are so interrelated, it is possible that exceptional skill in one area can compensate for a lack of strength in another. For instance a chief executive could have a brusque personal style but be a superbly efficient analyst, and strategic planner.

Skills in the area of conceptualization, however, are essential for competent executive functioning and cannot be compensated for by human and technical skills alone.

Subordinates and associates can often overlook some limitations in personal style if they can see the achievement of goals.

II. Graduate Programs to Achieve Management Skill

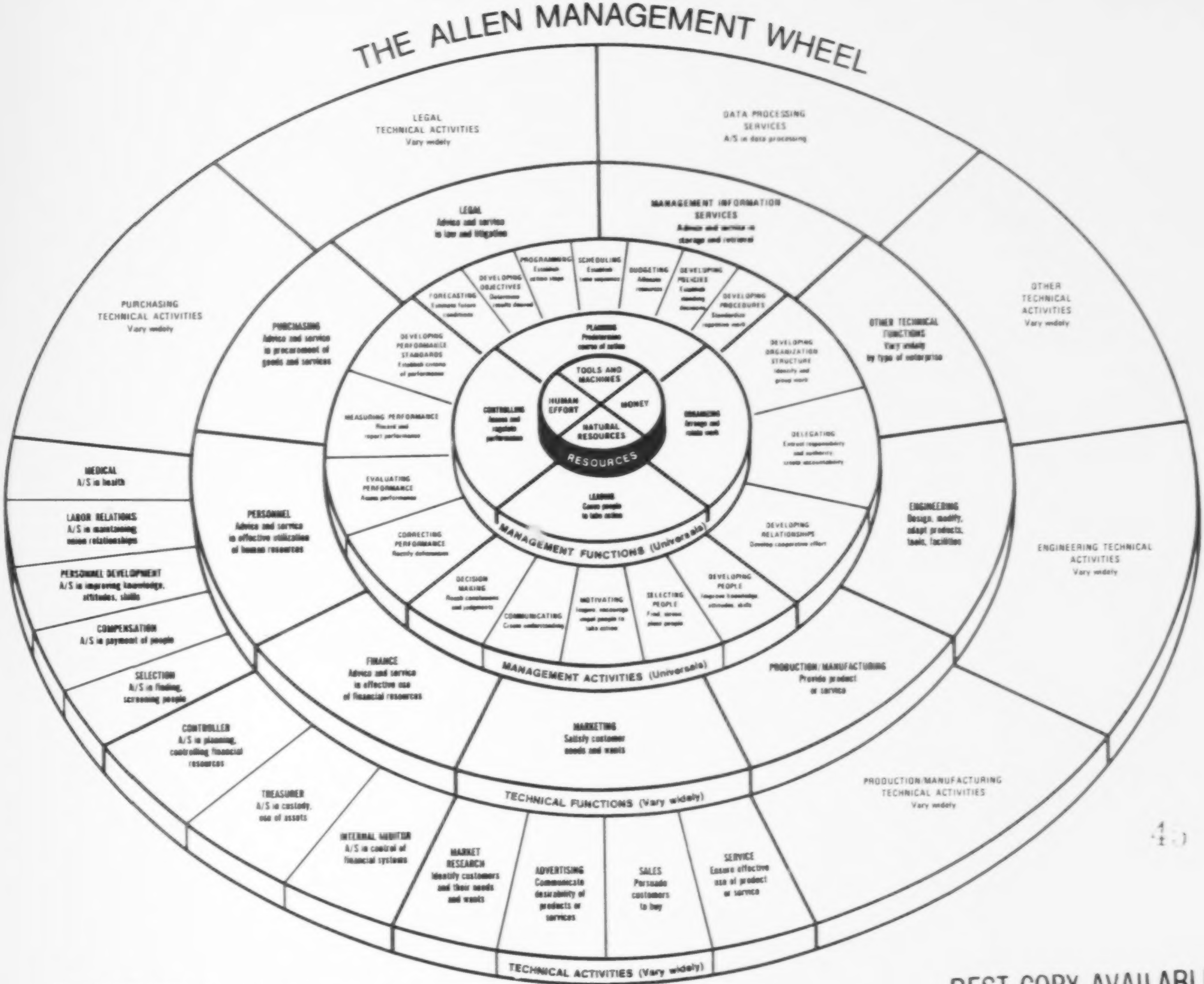
First let me illustrate what has been said by looking at a systematic representation of management and technical work.

Figure 1 shows the classification of human work developed by Louis A. Allen. In his research he found that all work done by people can be divided into two categories: technical work; that is, mental and physical effort applied directly to resources; and management work, which is work performed to secure results through other people. Both management and technical work can be subdivided into activities, segments and elements.

The innermost ring of Figure 1 represents available resources. The second ring, moving outward, identifies the four management functions. Planning is the work managers perform to predetermine a course of action. Organizing is the work done to arrange and relate the work to be performed. Leading is influencing people to take effective action. Controlling is assessing and regulating work in progress and completed.

Each of the four management functions can be divided into activities. These are shown in the third ring. Management work is the same for all professions and disciplines and in all cultures and countries. It is a universal.

The fourth ring shows the classification applied to technical work. Technical functions vary widely. Nursing is a technical function. So are surgery and anesthesiology. A manager, such as a nursing service administrator, is successful to the degree she or he can effectively manage (plan, lead, organize and control) the efforts of the people performing the technical work: (Medical, Nursing, Out-Patient Nursing, Surgical Nursing, Psychiatric Nursing, etc.)


THE ALLEN MANAGEMENT WHEEL
LEGAL
TECHNICAL ACTIVITIES
Vary widely
DATA PROCESSING
SERVICES
A/S in data processing
PURCHASING
TECHNICAL ACTIVITIES
Vary widely
OTHER
TECHNICAL
ACTIVITIES
Vary widely
LEGAL
Advice and service
in law and litigation
MANAGEMENT INFORMATION
SERVICES
Advice and service in
storage and retrieval
PURCHASING
Advice and service
in procurement of
goods and services
OTHER TECHNICAL
FUNCTIONS
Vary widely
by type of enterprise
FORECASTING
Estimate future
conditions
DEVELOPING
OBJECTIVES
Determine
results desired
PROGRAMMING
Establish
action steps
SCHEDULING
Establish
time sequence
BUDGETING
Allocate
resources
DEVELOPING
POLICIES
Establish
standing
decisions
DEVELOPING
PROCEDURES
Standardize
repetitive work
DEVELOPING
PERFORMANCE
STANDARDS
Establish criteria
of performance
MEASURING PERFORMANCE
Record and
report performance
EVALUATING
PERFORMANCE
Assess performance
CORRECTING
PERFORMANCE
Rectify deficiencies
DEVELOPING
ORGANIZATION
STRUCTURE
Identify and
group work
DELEGATING
Entrust responsibility
and authority
create accountability
DEVELOPING
RELATIONSHIPS
Develop cooperative effort
PLANNING
Predetermine
course of action
CONTROLLING
Assess and
regulate
performance
ORGANIZING
Arrange and
relate work
LEADING
Cause people
to take action
TOOLS AND
MACHINES
HUMAN
EFFORT
MONEY
NATURAL
RESOURCES
RESOURCES
MANAGEMENT FUNCTIONS (Universals)
DECISION
MAKING
Reach conclusions
and judgments
COMMUNICATING
Create understanding
MOTIVATING
Inspire, encourage
impel people to
take action
SELECTING
PEOPLE
Find, screen,
place people
DEVELOPING
PEOPLE
Improve knowledge
attitudes, skills
MANAGEMENT ACTIVITIES (Universals)
MEDICAL
A/S in health
LABOR RELATIONS
A/S in maintaining
union relationships
PERSONNEL DEVELOPMENT
A/S in improving knowledge,
attitudes, skills
COMPENSATION
A/S in payment of people
SELECTION
A/S in finding,
screening people
PERSONNEL
Advice and service
in effective utilization
of human resources
ENGINEERING
Design, modify,
adapt products,
tools, facilities
ENGINEERING TECHNICAL
ACTIVITIES
Vary widely
FINANCE
Advice and service
in effective use
of financial resources
MARKETING
Satisfy customer
needs and wants
PRODUCTION/MANUFACTURING
Provide product
or service
TECHNICAL FUNCTIONS (Vary widely)
CONTROLLER
A/S in planning,
controlling financial
resources
TREASURER
A/S in custody,
use of assets
INTERNAL AUDITOR
A/S in control of
financial systems
MARKET
RESEARCH
Identify customers
and their needs
and wants
ADVERTISING
Communicate
desirability of
products or
services
SALES
Persuade
customers
to buy
SERVICE
Ensure effective
use of product
or service
PRODUCTION/MANUFACTURING
TECHNICAL ACTIVITIES
Vary widely
TECHNICAL ACTIVITIES (Vary widely)

Copyright © 1979 by Louis A. Allen Associates, Inc.

Figure 1: The Allen Management Wheel

BEST COPY AVAILABLE

Figure 2 (adapted from the Allen model of Figure 1) demonstrates the same management functions in a nursing service (hospital) setting, with the product defined as patient care. The patient care objective requires concerted effort of all ancillary departments of housekeeping, dietary, laboratories, therapies, physicians, nurses; and even the participation of patients also. To add to the complexity of this model, a typical nursing budget for a 200 bed hospital is about $10,00,000 to $15,000,-000; and that for a 500 bed teaching hospital can reach $30,000,000. In industry this is considered a large budget. Yet to manage the typical nursing budget, the typical nurse administrator has little if any relevant educational preparation. Half do not have a bachelor's degree.

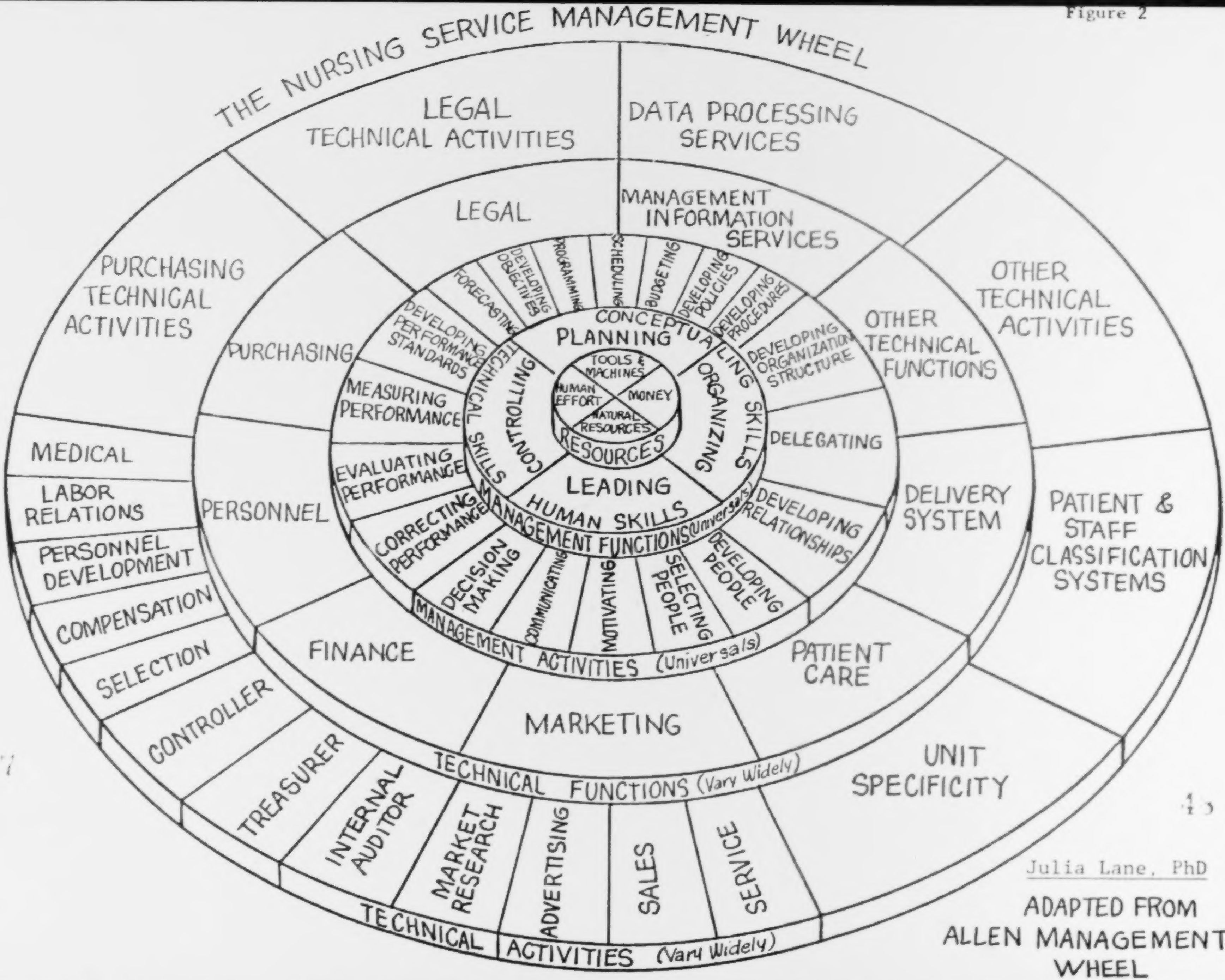
The wheel model of Figure 2 illustrates the complexities of demands on a nursing service administrator. While the outer two rings (four and five) are essentially advice and service for management functions and activities, the nursing service administrator must be prepared with sufficient technical knowledge to be able to ask the right questions and to evaluate the answers particularly in the area of patient care delivery systems, other related technical functions, finance, personnel, legal, and management information areas.

The elements needed in graduate programs to adequately prepare nursing service administrators can be determined by re-stating the model as shown in Figure 2. Such programs should:

1. develop the technical skills related to patient care and management activities.
2. develop skills related to human behavior for organization effectiveness; and
3. enhance the conceptual abilities of the nurse manager enabling her to implement the vision of the organizational mission.

III. Recommendations for Educational Programs to Prepare Future Nursing Service Administrators

A review of the NLN-accredited masters programs reveals that there are approximately thirty university or


THE NURSING SERVICE MANAGEMENT WHEEL
LEGAL TECHNICAL ACTIVITIES
DATA PROCESSING SERVICES
PURCHASING TECHNICAL ACTIVITIES
OTHER TECHNICAL ACTIVITIES
LEGAL
MANAGEMENT INFORMATION SERVICES
PURCHASING
OTHER TECHNICAL FUNCTIONS
FORECASTING
DEVELOPING OBJECTIVES
PROGRAMMING
SCHEDULING
BUDGETING
DEVELOPING POLICIES
DEVELOPING PROCEDURES
DEVELOPING ORGANIZATION STRUCTURE
DELEGATING
DEVELOPING RELATIONSHIPS
DEVELOPING PEOPLE
SELECTING PEOPLE
MOTIVATING
COMMUNICATING
DECISION MAKING
CORRECTING PERFORMANCE
EVALUATING PERFORMANCE
MEASURING PERFORMANCE
DEVELOPING PERFORMANCE STANDARDS
CONCEPTUAL SKILLS
TECHNICAL SKILLS
HUMAN SKILLS
PLANNING
ORGANIZING
LEADING
CONTROLLING
TOOLS & MACHINES
HUMAN EFFORT
MONEY
NATURAL RESOURCES
RESOURCES
MANAGEMENT FUNCTIONS (Universals)
MANAGEMENT ACTIVITIES (Universals)
MEDICAL
LABOR RELATIONS
PERSONNEL DEVELOPMENT
COMPENSATION
SELECTION
PERSONNEL
FINANCE
MARKETING
PATIENT CARE
DELIVERY SYSTEM
PATIENT & STAFF CLASSIFICATION SYSTEMS
UNIT SPECIFICITY
CONTROLLER
TREASURER
INTERNAL AUDITOR
MARKET RESEARCH
ADVERTISING
SALES
SERVICE
TECHNICAL FUNCTIONS (Vary Widely)
TECHNICAL ACTIVITIES (Vary Widely)

Julia Lane, PhD

ADAPTED FROM
ALLEN MANAGEMENT
WHEEL

Figure 2: The Nursing Service Management Wheel

college programs offering graduate education with a major in administration, management, or supervision. These programs vary in length from two semesters and a summer session, to six quarters or four semesters, or from 30 to more than 60 credit hours of instruction.

It is unlikely that the graduates of such a variety of programs have equivalent preparation.

Alternatively, some nurses who aspire to administrative roles within nursing seek to gain administrative competencies both in and outside the profession. McClure (1979) has described these in the form of a continum shown in Figure 3. Only the last of these programs may adequately prepare nurse administrators for the scope of activity required for the nursing service of today. Certainly a masters degree without any clinical nursing component does not prepare the graduate for her chief responsibility -- that of giving leadership to the nursing staff. It is true that the first three types of programs may give more technical skills in business but the real essence of administration is in the conceptualization of the relationship of nursing's role in achievement of the mission of the institution. The percent of the time spent in leadership conceptualization increases as the nurse moves from lower to higher levels of nursing administration.

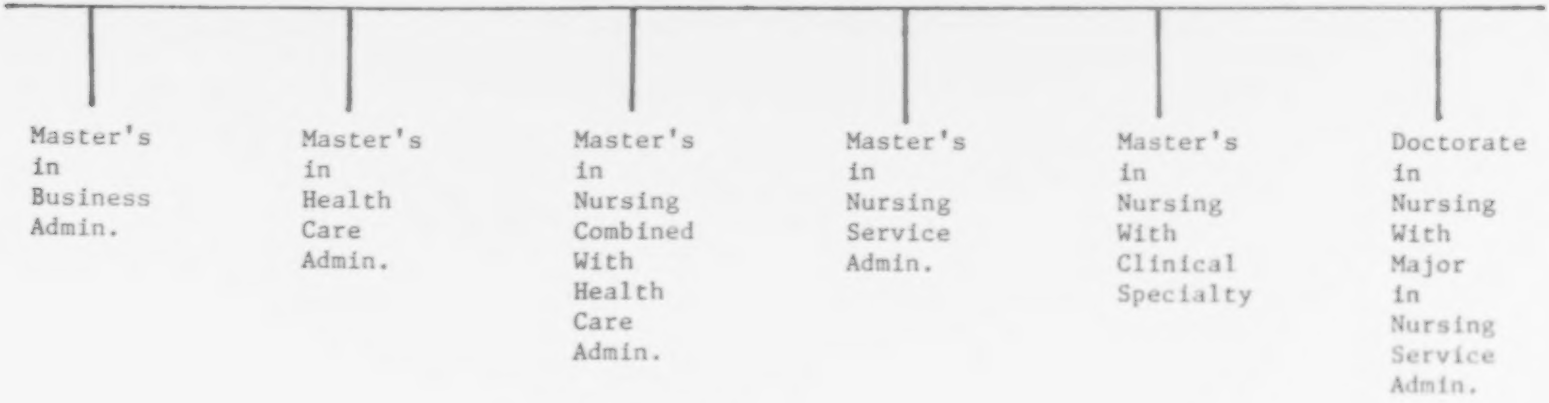
Two types of nursing administration programs are needed: the first a mid-level management program and the second an executive administration program, the latter at post masters or doctoral level.

The mid-level program would focus on the area of technical and human skills for improvement of patient care quality. Nursing staff are helped to solve complex nursing problems with achievement of professional satisfaction. Graduates would be qualified to fulfill roles from the level of head nurse to associate nursing service administrator, depending on experience and personal ability. A curriculum for this is suggested in Figure 4.

Whatever programs are currently proposed are merely a stop gap measure. Nursing service administration, like educational administration, ultimately requires doctoral preparation. At present about eleven such doctoral pro-

Figure 3

CONTINUUM OF TYPE OF PREPARATION PROPOSED FOR NURSE ADMINISTRATORS


Master's in Business Admin.
Master's in Health Care Admin.
Master's in Nursing Combined With Health Care Admin.
Master's in Nursing Service Admin.
Master's in Nursing With Clinical Specialty
Doctorate in Nursing With Major in Nursing Service Admin.

McClure, Margaret
Nursing Adm. Quarterly 3
(Summer 1979) pp 1-12

Figure 4: A proposed program model for nursing administration (based on the adapted Allen model shown in Fig. 2)

		Credit Hours
Technical Skill	Advances in Nursing as a Discipline	12
	Advances in the Clinical Practice of Nursing	6-12
	Theory and Practice of Administration	6-12
Human Skill (9)	Human Development	
	Group Dynamics	
	Role Theory	9
Conceptual (6)	Issues in Health Care Delivery	3
	Issues in the Professionalization of Nursing	3
Cognates	Organizational Behavior	6
	Management Information Service	
	Management of Financial Services	

grams exist, four of which are in MAIN's region. But first we must face the problem that half of the nursing service administrators are not educated at the bachelors degree level. This problem needs to be addressed first to identify the essential technical, human and conceptual skills for the effective practice of nursing administration; and second to design a program that will facilitate the movement of the greatest number of nurses toward achievement of the masters degree. If we are to develop such a model program as part of regional planning in MAIN, the wheel model has great potential for unifying the wide diversity among educational designs toward a common curriculum base for sound preparation for nursing administration.

Secondly, those university-based colleges of nursing having adequate resources should develop doctoral programs using the model as a curriculum base. In this way our ablest and brightest nurses might move quickly to the doctorate, acquiring desirable skills in research design, evaluation methodologies, health planning, policy formulation, and improved delivery systems -- all advanced conceptual skills.

Third, our present nursing service directors should actively seek to identify and arrange mentor experiences for young nursing staff who have the potential to become nursing service administrators of the future. Potential nurse leaders should be encouraged to obtain experiences which expand their knowledge and level of responsibility, thus enhancing their ability to conceptualize.

Lastly, we need to discuss the plan of the MAIN task force as proposed by its chair, Dr. Schlotfeldt. We are a diverse constituency but if we were willing to identify expert faculty in the region and work together to accept a common core of identified human, technical, and conceptual skills for a curriculum base in nursing service administration, we could move the profession forward in an atmosphere of collegiality and collectivity.

No one has yet proposed the perfect plan or even the best possible answer; but as a profession, we must improve nurses' ability to appreciate and use administrative power based on reliable knowledge, gained through appropriate education and mentored administrative experience.

References

Allen, Louis A., "The Allen Management Wheel", in Professional Managers' Guide, Louis A. Allen Associates, 3600 W. Bayshore Road, Palo Alto, CA, 94303, 1975.

Brown, Barbara, Clinical Nursing: A Basic for Administrative Excellence. Nursing Administration Quarterly, Vol. 3, (Summer, 1979) pp 19-25.

Katz, Robert L., Skills of an Effective Administrator, Harvard Business Review, Vol. 52 (Sept/Oct. 1974) pp 90-102.

Kolter, John P., Power, Dependence and Effective Management, Harvard Business Review Vol. 55 (July-August 1977) 125-136.

Leininger, Madeleine, Leadership in Nursing: Challenges, Concerns, Effects. In Proceedings of Two Nursing Administration Conferences, Tempe, Arizona, College of Nursing, Arizona State University, 1974, pp 35-53.

McClure, Margaret L., "The Administrative Component of the Nurse Administrator's Role" Nursing Administration Quarterly, Vol. 3, (Summer 1979) pp 1-12.

McGregor, Douglas, Leadership and Motivation, Cambridge, Mass., MIT Press, 1966.

Poulin, Muriel A., Education for Nurse Administrators: An Epilogue. Nursing Administration Quarterly, Vol. 3 (Summer 1979) pp 45-51.

Discussion

Moderator:

We have time now for questions before we move to the next speaker. Would anyone care to ask Dr. Lane a question, or express a comment at this time?

Question:

You mentioned that there were a great number of nurse administrators in our country that do not hold bachelors degrees. I am wondering if the task force considered, in its proposed plan, certificates that might be awarded to people who were not interested in pursuing a bachelor's degree, but who could earn credits toward the certificate. This could be an option for some of them as an alternative to the degree because some people coming into our educational institutions become frustrated with the educational system's inability to give credit for experiential learning. One way of supporting that group could be through some kind of certificate. Would the task force see that as an appropriate option?

Answer:

The Minnesota and University of Illinois programs have offered a certificate. It was the thought of our task group that in a credential-oriented society such as ours, certificates simply do not command much repect. Remember that hospital administrators are prepared at the minimum of masters degree. Nurse administrators should have at least the same credential. When physicians have to call the nurse "Doctor", it changes their perception of the nurse. When they know you are credentialed at the same level they are, it commands their respect. If we could get more doctorally prepared nurses, nursing would have more power. This is not to say that having the degree automatically makes the nurse more competent. Obviously, the nurse must demonstrate competence in addition to the degree. But the degree will open doors for nurses. For this reason I would recommend the proper academic credentialing process, rather than a certificate.

Comment:

I agree that the credentialing or official recognition accorded to education for nursing service administration should be firmly established in the university. I have little sympathy for the nurses who have held administrative positions for a long time, getting better salaries, and having done nothing to further their educational qualifications.

Comment:

I agree that it should be necessary for nurses to be appropriately credentialed for their role. It is necessary that nurses have a liberal education and a knowledge base as well as the advanced preparation in administration. Both of those things go together. We must assume that, in the formal basic preparation of nurses at the baccalaureate level, there is provided a knowledge base upon which to build for practice, whether that occurs in academic institutions, or in clinical settings. It would be a poor vision, and it would give a poor public message -- for me it would be entirely out of order -- to give the impression that a certificate could be substituted for an academic degree.

NURSING ADMINISTRATION IN A SMALL RURAL HOSPITAL

by Janice Doxtader

> *"I am a resident of Eaton Rapids, Michigan. Last night my little boy was outside playing. He had never before been affected in any way by a bee sting, but last night he was stung on the arm by a bee, and within a matter of moments his face had swollen remarkably. He had a very serious physiological reaction. I took him to Eaton Rapids Hospital and he was seen by the physician. I am very thankful for the existence if that hospital because, had it services not been available, my little boy might not be alive today. If our Eaton Rapids Hospital were not there I would have had to take him to Ingram Medical Center or Sparrow Hospital in Lansing which is about a twenty-five minute drive from my home. So today, I am very thankful for that hospital and those doctors. Otherwise, I might be at a funeral home today making arrangements for that child."*

The testimony quoted in the above paragraph was one of the many dramatic presentations given by consumers at a public hearing two years ago during discussion of a proposed Michigan State Facilities Plan. Because of the impact of small hospitals and the overwhelming public support of them, the State tabled its plan to close the Eaton Rapids Hospital.

I mention this primarily because it is typical of the support that communities give their local hospitals when curtailment of services is threatened. Our community is especially proud of its hospital because it was built, added onto, and remodeled all with local funding only. No government funds or loans have ever been used.

Community hospitals are defined as those hospitals that serve a community, are not-for-profit institutions, and that have fewer than 100 beds. The proportion of small community hospitals to the total number of hospitals is impressive. I quote American Hospital Association data on the number of 99-bed or less community hospitals in the MAIN region, for example: 80% of South Dakota's hospitals are in this category; Nebraska has 77%; Kansas - 74%; Oklahoma - 68%; Michigan - 40%. The percentage is, of course, smaller in the more populous states. The overall percentage for the MAIN area is 50.5%. Therefore, I am pleased to represent this large number of hospital nursing administrators.

Briefly, I will tell you of my background. I grew up in a southwestern Minnesota rural community -- Lakefield. Farming is the predominant activity there. My basic education was obtained at Hamline University in St. Paul; and following this I completed the Public Health Nursing Program at the University of Minnestoa. As a student there, I had clinical experiences in rural Western Michigan. I chose to locate in rural Eaton County, Michigan. Because of my Eaton Rapids-born husband's job, we moved to Eaton Rapids, still in Eaton County. Many of the people do (or did) work for auto-related industries, state government, and other employers in the state capitol city of Lansing, twenty miles away.

I began working as a staff nurse at the local 44 bed hospital one evening a week. Now -- 22 years later, it is a 41 bed hospital, where I am the Assistant Administrator. Our primary hospital services include medicine, obstetrics, surgery, emergency room, laboratory, radiology, respiratory, and physical therapy.

Many changes have occurred in these 22 years. In the first five years during which I was Director of Nursing I was singly responsible for staffing, scheduling, orienting, supervising, and providing inservice education, all without clerical help. I am grateful that this has all changed within the last three years. Now I have a clinical director who has her own part-time secretary to assist her with scheduling and staffing; an inservice education nurse who also takes care of orientation and infection control activities. In addition I have my own full-time secretary.

During the eight years I have been Director of Nursing, I have worked under three different full-time and two short-term acting administrators. Each of them has had a completely different style of management and philosophy. There were times when my position seemed very precarious. For the last two years our administrator has been supplied by a management contract with a neighboring, larger hospital.

Thus, in the smaller setting, the nursing administrator must be involved in more than nursing or patient activities. Overall administrative responsibility is required not only for nursing services but for physical therapy, housekeeping and laundry, dietary services, social services and the library. As my focus was required to change, naturally my skills have shifted, from clinical management. There are still a few who expect me to step in whenever a nursing vacancy occurs. These are usually on the night shift!! Many small hospital nursing administrators do fill in on some shifts.

JCAH Regulations -- one size fits all

Small hospitals like large ones must live by the same rules and regulations of the Joint Commission on Accreditation of Hospitals (JCAH). At our last survey, an administrative person accompanied the team in an effort to evaluate the practicality of their standards as applied to the small hospital. After recently checking with JCAH, I learned that they do not plan to further revise the rules to adapt them for small hospitals. An example of a JCAH ruling that is a prohibitive expense for small hospitals is the one on smoke-activated dampers in smoke barrier walls. The estimated cost for this correction alone at our hospital is $50,000. Agreed, it may be a fine safety precaution, it is nevertheless an unrealistic expense to implement in an existing structure, particularly when Michigan State Fire Code does not require this.

Many JCAH standards do help nursing administration, though. For a long time it was difficult to get nurses to do thorough initial admission assessments. Because of the JCAH standard requiring this, we now comply with it.

Financial Dilemmas in the Small Hospital

Understanding finances, budgets, cost reports are another of the nursing administrator's challenges. Two years ago our hospital contracted for pharmacy services, which were in much need of updating. Until then, we had an arrangement with a downtown pharmacist who furnished medications from his drug store supply on a daily basis. Nurses were using medication cards and were also preparing all intravenous solutions. Charging for medications and medication-related services was very inconsistent and inaccurate. Now we have unit doses, daily reconciliation, audits, admixtures, including hyperalimentation -- a pharmacy service to which I point with pride. But the price tag associated with these outstanding programs has had a phenomenal impact on the hospital's financial picture. I have learned about disincentives, rate reviews, etc. Our hospital is anxious for the five year contract to be fulfilled so that we will not have to continue this costly service. I am reluctant to see changes made in such a fine operation.

The nursing staff at our hospital traditionally has not been very involved in charges. Just because every item now has a charge ticket on it doesn't mean they like knowing about it either. Missed and haphazard charging is a constant, nagging issue for me. For example, nurses are reluctant to charge patients for intravenous supplies if the IV is unsuccessful.

The small rural hospital is no longer exempt from litigation or the threat of it. In its first twenty-five years of existence our hospital never had a lawsuit against it. Now we have one case on the court calendar, and two more pending. If these continue to expand, insurance premiums may become overwhelming. One of our physicians has always maintained that we should settle the case by offering to give the hospital to the plaintiff, to let him experience the responsibility it entails. He feels public pressure would create problems for the awarded party, and important lessons would be learned.

Medicare, Medicaid, and third party payers have a dynamic impact on the small hospital's financial planning. Current Michigan Medicaid rulings practically prohibit us from treating these patients, because if you do treat, it is almost certain that the treatment is on the non-payment list. With the unemployment rate, influenced in so many Michigan communities by the sagging auto industry, we are not envied by any other state. It all means more persons will be eligible for the Medicaid non-benefits. How to keep the nursing staff from being in the middle of this muddle, especially in the Emergency Room, is another challenge.

Our physician coverage for Emergency Room is provided by 24-hour, on-call rotation of the active medical staff. A determination must be made whether situations are life threatening, as Medicaid reimbursement requires this. Having a convenience or outpatient clinic for non-emergent cases has been suggested as a remedy to ease the pressure on the medical staff; however, they quickly declined this suggestion, as they already work all the hours they care to work.

Many employers in Lansing gave their employees a choice for health care coverage. A number chose the Health Maintenance Organization (HMO). When an emergency occurs, the patients from our community come to our Emergency, rather than drive twenty miles to Lansing. After we make a thorough assessment we need to call for authorization to treat. This is often another irritant as we have already provided the service.

The key to any activity in a small hospital is turned by the physician staff. Our community was unique for a long period of time because all the physicians were united in one professional corporation of six physicians.

We read in the Rand Study about the over supply of physician specialists. This over supply is impacting our small hospital already. Two osteopathic physicians have chosen to branch out to our community to set up an independent practice. This created an immediate threat to the old guard physician group. Increased activity, new interventions, and new proposals were now introduced. It sent our occupancy level up to an acceptable percent; but whether this level of activity can remain high is a constant question. When even one physician goes on vacation, our census drops in direct proportion.

Specialists are finding our hospital a part of their market place. We now have regular consultation services in gastroenterology, orthopedics, and urology; with plans to add a neurologist soon. Our regular staff includes two board certified surgeons, two internists; and two family practitioners, one of whom doubles in anesthesia and the other in optometry.

With the physicians broadening their scope of practice, the demands on the hospital budget and the nursing staff to meet these patients' needs is overwhelming. Each of our nursing staff has to be a "jack of all trades". She must have detailed knowledge and skills in so many areas. Frequently patients are personal friends or relatives. Even though we still have a six bed obstetrical unit, with only one or two patients at any one time, (and nursing care should be par excellence under these conditions), it is nevertheless difficult to orient staff and to keep up their skills. When this unit closes from time to time, staff must work on Medical/Surgical units. You can already guess what this does to the staffing schedule. We must not be overstaffed in relation to patient classification, and still we must produce qualified personnel immediately if the unit opens. As we plan for the future of this obstetrical unit, we consider alternative uses such as intensive care areas, outpatient clinics, or swing bed concept, taking the acute patient to the smaller hospital for convalescence. These alternatives need to be analyzed for cost effectiveness.

Our hospital is no exception in shifting emphasis to out-patient surgery. Because of this we have added a post-anesthesia area. Finding additional space to house these services is a problem.

I mentioned the staffing headaches in relation to the obstetrical unit. Nevertheless, we feel we have many opportunities for nurses. We do give personalized, family-centered care. We are close to educational institutions. We do have "flex" schedules, having recently introduced twelve hour shifts. But, we are primarily dependent for nursing staff on those individuals who marry and take up residence in our community, just as I did 22 years ago. We seem unable to attract young nurses, unless they fit into that category. We are employing undergraduate nurses for weekends and vacations, but usually they want to go to an intensive care unit after graduation. We are paying a number of LPN's to go back to school to become RN's, hoping they will fulfill their obligation to us.

Keeping salaries competitive is a part of the problem. The local residents on the board are small business men and women who find their own incomes declining. With the sacrificies the auto industry workers are making, the nurses must be aware they cannot expect so much. So, even our supervisors make less than most staff people in the larger, neighboring hospitals.

Alliance with a larger city hospital has allowed us to draw on nursing expertise to teach inservice education classes at a somewhat reduced cost. We are now offering a basic arrhythmia class for RN's, LPN's, and respiratory therapists.

As our nation becomes computerized we, too, expect to be involved with their use. We have a computer located in the clinical director's office already. Physicians are planning to be programming orders as the first step. I plan to enroll in beginning computer classes through the Community Education Program.

At the June annual meeting of the Michigan Society for Hospital Nursing Administrators, I listened to another small, rural nursing administrator tell about her 20 bed community hospital with two physicians on staff. She said the practice there was comparable to what she learned in the 1940's in the Nurse Cadet Program. It certainly made me appreciate the progress our hospital has made in the last few years.

As we look to the future a new five year plan is being prepared, a great deal of data is being reviewed. We note our Medicare occupancy rate, zero community growth, and declining birth rate. One elementary school was closed this year. The "down" curve of industry in the state also presents a negative impression. Our hospital board feels the need to create a Development Council to help project the hospital's image to the public. This activity is believed to be a necessity because we no longer have our small town newspaper. I have agreed to do this because I see this mutual tie with our community as one of our main resources for survival.

The council is comprised of local leaders with one person named general chairman and four other committee chairpersons for annual support, community relations, foundations/corporations, and deferred giving. These committee chairpersons are choosing their committee members now; and while I am here, my secretary is getting together a slide show with which to indoctrinate all these committee people in relation to the services the hospital is currently providing. There is emphasis on wellness. General programs and literature will be produced to promote it. Already this year all the hospital auxiliary programs have contained this theme of wellness.

And, if capital funds will eventually be forthcoming as is being projected, I want them to be designated for much needed new electric beds and other patient care equipment. The operating budget has so narrow a margin for profit that we may never get these otherwise.

The challenges of the next decade for the rural community hospital nursing administrator are many. Surely, understanding community organization, hospital budgeting and finance; cautious and thorough planning, and development of personnel are all mandatory. Trial and error has often been our teacher, but can we any longer be allowed to fall back on this method? Improved networking among hospital nursing administrators will certainly help us. The question today is -- can and will educational institutions also help us to meet these challenges?

Discussion

Moderator:

Questions may be directed to Ms. Doxtader at this time.

Question:

I would like to thank Ms. Doxtader for her graphic portrayal of her work. She has brought us back to reality. I would ask her a question -- she didn't comment on the impact of proprietary hospitals, and the chains of proprietary hospitals, that are cropping up all over the country, gobbling up the small community hospitals. This is a major shift, I think, because the community hospitals in this country have been the backbone of our small town health care systems. I wonder if she would comment on this topic?

Answer:

Thank you. I would like to. In Michigan we are now seeing that the proprietaries are absorbing as many as they have in some of the other states. To prevent that we depend on the management contract arrangement I described. Our hospital is twenty miles from Lansing, the State center. A few years ago, one of the hospitals in the Saginaw area came to our hospital to present a proposal to us for establishing a consortium. At that time we felt we did not want to go with Saginaw bacause that was too great a distance to commute for health services. The other small hospitals in our county have the same arrangement that we do for management contract with a larger city hospital. Our community and our staff resent losing that vital home-town control, which puts the administrator in jeopardy. It is a difficult situation, but the community's feeling of ownership may deter the proprietaries from moving in, at least in Michigan.

NURSING ADMINISTRATION IN A COMMUNITY HEALTH SERVICE

by Gertrude Hotaling, MPH

Some years ago I employed a person to redesign my back yard so that it would be attractive and at the same time easier to maintain. Part of the design was placement of crabapple trees in the northwest corner of the yard. At the time the work was done the ground was fertilized and metal barriers were placed to prevent the growth of bermuda grass into the area that ws to contain roses, iris, tulips, daffodils, and other bulbs. The crabapple trees and supports for them were put in place. In the fall when the work was completed I looked at it with expectation of what the spring would bring. The weeds were gone, the ground was suitable for growth, the new trees were firmly established and the plans were made for necessary continued upkeep. But the plans that were so eagerly made did not fulfill the expectations. In particularly, the trees today are very different from one another -- without apparent reason. One tree was so full of blooms this spring and subsequently had so many apples that there was need to trim the branches to prevent the destruction of the tree. The other tree had one or two blooms, no apples and is only one tenth the size of the larger tree. Although they started out similarly fertilized, watered, and cared for (I think I have even talked to them), the outcome for each has been markedly different.

The difference in these trees can be compared to the difference in outcomes of nursing administration in different settings. If they are equal when planted, do they all have the same potential for growth and productivity? Apparently not. Differences also become apparent when two registered nurses with different basic preparation and abilities are placed in similar administrative positions. In the past and continuing today, many nurses increase their economic return by moving up the ladder into supervision or administration. This move is often made with neither the basic nor the advanced preparation necessary to prepare the nurse for a position of greater scope and responsibility. The eventual role assumed and the work performance of the nurse without such preparation will differ from that of the nurse with a baccalaureate degree in nursing, graduate preparation in administration of nursing, and clinical nursing experience. A nurse cannot just become an administrator, she has to know what she is administering. Thus even though similarly fertilized, watered, and given similar does of sunshine, one of my previously-mentioned crabapple trees obviously had more to begin with than the other. Even so I am still trying to supplement the least beautiful and least productive one. I haven't given up, but my expectations for the future of each tree are markedly different.

This is analagous to the differently-prepared nurse administrators. We don't throw out the least prepared or the least productive, but rather continue to augment their limited knowledge with short courses and on-the-job education. Now, we plan to change the future by establishing educational programs to increase basic knowledge of the nurse as well as the specialized knowledge needed for the practice of administration in nursing. It is impossible and probably foolish and expensive to do this state by state because of the limited numbers of prepared nurses available. The Midwest Alliance in Nursing, whose development came about because of an expressed interest in, and acknowledgement of the need to promote a rational system of education in nursing, to improve nursing practice, and advance research in nursing is the logical group to focus on how we can better meet the needs for education of nursing administrators.

My assigned topic is nursing administration in a community health service. Community health services are offered in different kinds of settings depending on: the purpose of the agency; whether it is a public agency established by state statutes, or voluntary; or specialized and giving only one kind of care; or a profit agency; or not for profit; and what size area the agency covers, i.e., state, county, city, or multicounty areas. These differences determine the activities of the agency. These differences also affect the staffing mix and suggest the needed level of educational preparation for the staff. In the Oklahoma State Health Department we serve seventyseven counties. I work closely with sixty-one county health departments and two larger city-county divisions. In addition there are fourteen unorganized areas which contain about 5% of the state's population.

In this presentation, I will cover the elements of nursing administration and specific problems related to the process in community health with suggestions for the future. Nursing administration in any setting involves working with a variety of layers of personnel. When this process is in community health service it takes place in a setting which may be single or many-layered in addition to the involvement of the multidisciplinary team.

In all community health settings nursing administration is concerned with the following elements:

1) planning what needs to be done in order to facilitate the practice of nursing where direct nursing services are given;

2) development of ways to coordinate activities between nurses in local health departments, specialized program areas, and other agencies in the community;

3) monitoring the quantity and quality of services;

4) providing technical assistance to the overall administrator on all matters relating to community health nursing, performance, practice and activities;

5) determining goals and direction of the community health nursing component; e.g. standards, functions, and policy related to specialized program areas like maternal and child health, chronic disease, tuberculosis and respiratory disease. Goals and standards are based on the professional nursing standards already established by the professional association;

6) establishing a staffing plan to meet the needs of the people we serve -- one plan for what is really needed and another plan based on what is really possible because of limited budget;

7) budgeting and monitoring of financial status throughout the fiscal year.

   In our setting this means working with three budgets before you get to the real one. It seems to be a constant process of proposing a budget, proposing individuals you would like to add on, expanding your work, revising that, and then when the money finally comes, adjusting the program and establishing the work program;

8) recruiting, interviewing, recommending, employing prospective employees;

9) evaluating personnel;

10) preparing annual reports and reporting activities to the overall administrator of the agency;

11) monitoring nursing statistics for the total population and also for high risk populations;

12) participating in quality assurance programs and reviewing the results of audits;

13) reviewing legislation to determine its impact on nursing services and suggesting legislation that is helpful to the provision of nursing services;

14) participating in arranging contracts related to student clinical experience in community health for schools as far away as Kansas and Texas;

15) representing the department and/or nursing at professional meetings or as a member of an advisory group or task force;

16) convening groups regarding new or revised methods of record-keeping to meet client needs;

17) writing job specifications congruent with the state's merit system.

Community health settings may be geographically many miles away from administrative headquarters. We find that risk populations and resources may be different in all or many of the settings; and there is a constant need to provide the direction for the programs appropriate to the needs of clients, supervisors, consultants, and staff nurses. Administration in community health is diffuse and requires nurses that can function independently and are able to ask appropriate questions and report appropriate information.

Distance from headquarters and differences in the needs of a population and preparation of the staff require careful planning and communication.

In the decade ahead there are several important considerations:

1) There is a continuing need for preparation of nurses in community health including participation with multidisciplinary teams. In some programs community health is ill-defined, and the student emerges not really prepared in community health. That is something that education and service need to work toward;

2) The continuing delay in establishing baccalaureate degree as the basic preparation for professional nurses who will be administrators of the future will further delay appropriate graduate education unless those programs require that basic education;

3) Decreased funding of community health services may force reduction in staff, particularly the newer staff who do have the baccalaureate education in nursing. We have a policy in the State Personnel Board and the State Department for retention, in relation to what reduction in force (RIF) means. Somebody that has worked for a long time and has average or above average evaluations will be retained over the person who has had short term employment and has a baccalaureate degree. This policy may impede progress to some extent in the State public health system. This is different from policy in voluntary agencies;

4) The leadership pool is limited at this time. We accept people that come in with a baccalaureate, AD degree, or diploma. There are different salaries for these positions and therefore we have to work closely with the administrator who is handling the budget at the local level so we don't get all people of the lower classification for the sake of lower salary;

5) Increasing provision of clinical services in health-centers and less direct services to clients in their homes. I have a concern for this trend in terms of public health because I think we are in danger of becoming something different than we were. We are overwhelmed with people wanting clinical services who come to our clinics for necessary services but I think we are losing some of the important aspects of case-finding, and really understanding the community and the practice of community health nursing;

6) The need for the application of computer technology. In the decade ahead all staff will need to have a

better understanding of the computer and its use in providing services;

7) The lack of nursing administrative positions in some states and, therefore, no community health nurse administrators at the State level. There are a number of States in which there is no defined nursing position at the State Health Department;

8) Increased numbers of other professional groups will serve the health care needs of the public. One group in existence in Oklahoma is the child development specialist. This is not a nurse but a person prepared in that area. They are doing a good bit of work in parenting. There is competition among professionals as over supply of some results in changes in their scope of practice. In the next ten years these trends will have an affect on public health nursing.

Implications for the future:

1) Nursing administration requires preparation in theoretical and scientific content of nursing administration and in the area of public health, with experience as a practitioner under nursing administration that exemplifies the best available at the time.

   Experience for new staff should include participation in the decision-making process and acceptance of accountability to the client for the provision of nursing care, and accountability to the department for which they work;

2) Nursing administration must be willing to participate as mentor for students and provide grooming for staff qualified to move into future administrative positions;

3) Nursing administrators must be involved in and be aware of the political process, and must be involved outside of their own setting with other institutions, agencies, and, of course, the professional organizations. I would hope that this content could become a required part of education in administration;

4) Care must be cost effective and should give priority to the high risk populations.

These are things that we need to be working on, and that are within the realm of nursing activity. A nursing administrator and community health nurse can not function without organized, mentored clinical experience.

NURSING ADMINISTRATION IN A HEALTH SCIENCES CENTER

by Gabrielle Martel

You are looking at a nursing administrator that has been in nursing administration in academic centers for about twenty years, and I guess I probably should get some awards for "stick-to-itiveness". But never, in all my activities, did I ever forget that I was a nurse. The fact that I was a nurse influenced all my decisions. I have been delegated by one of my fellow nursing administrators to make a recommendation to M.A.I.N., based on our heated discussion this morning, that if we really want to collaborate and work together let's get rid of the separate identification ribbons.*

All day we have been focusing on nursing education for nursing administrators with the elements of what that education ought to be. We have a lot of detail about how people should carry our their role. We have heard heated opinions about the clinical component, and I am reminded very strongly of my good friend, Mary Kelley Mullane whom many of you know and who was one of my mentors. She believed that a nursing administrator's specialty was administration and she drove that point home fifteen or twenty years ago. You all know that nursing practice and nursing administration have really done a 360 degree turn in that time period. Nevertheless with much improvement. It is mind-boggling for those of us in nursing administration to reflect on the drastic changes in the past year in terms of the nursing shortage issue. And now MAIN has asked us to look into our crystal ball to predict the next decade. Bravely, I will do so but with a qualifier that things do change rather rapidly. As I was preparing my comments for today I thought about the fact that if this were a year ago I might be saying very different things.

---

* At conferences, MAIN's service agency representatives were up to this time, identified by yellow ribbons attached to name badges; and education agency representatives by blue ribbons. The representatives' consensus, following this remark of G. Martel, was to do away with this 3-year tradition as evidence of the unity of nursing service and nursing education.

Within the time alloted I want to describe the setting, and the changes in the setting of a health science center/university hospital. By now we have reinforced many beliefs you already held about what should be incorporated in the education of a nursing administrator. I propose to talk about nursing administration in the health science context and share with you what I see developing over the next ten years. Money is fundamental in affecting these developments.

My world is that of Vice-President of Nursing in a thousand bed hospital -- the major teaching hospital for Northwestern University College of Nursing and School of Medicine. We have about 1,660 employees in the nursing department. Of that 1,660 employees about 1,100 are registered nurses. Of the 1,100 registered nurses about 860-67 (this number changes every day) are staff nurses. Of that number of staff nurses 70% have baccalaureate degrees. I present these figures because as I listened to my colleagues from Eaton Rapids, this morning, I realize we are in two different worlds. If we hope to set up the most appropriate educational curriculum for nursing administrators we must consider that. It is important for us all to realize the different arenas in which we work.

You hear repeatedly that hospitals are big business. Because large hospitals are considered to be "well off" they are targeted by the various governments and third party payors throughout the U.S. to reduce costs of health care. Many here today could tell you about the impact it makes on how they can deliver patient care, and what kind of care they can deliver. It is important to know that there are 7,000 acute hospitals in this country. In 1978 the health care costs in those 7,000 hospitals stood at 71 billion dollars, so you can see that the federal government and all the third party payors are looking at us as the one type of agency causing most of the spiralling costs of health care. The nursing administrator, by virtue of her position and her responsibilities, has to be part of the discussion when looking at these issues. One other important statistic to remember is that 70% of U.S. nurses work in hospitals. Although that may surprise many people, that is a valid 1981 figure. So last year's issue, raised at the hearing of the National Commission on Nursing, relating to diminishing numbers of nurses entering hospital nursing as a career has noticeably changed. At any rate, we are in an industry which lies at the focal point of the groups that are looking at health care costs. Conclusions that are reached by these groups are that the inpatient care, particularly in an academic health center is expensive. You may understand we get a little gun-shy about being told to be more accountable for how we spend our money.

Hospitals, particularly the hospitals that I represent, have responded to these influences in a variety of ways. Most of them have incorporated. The title 'Vice-President' is a corporate title. We have incorporated, as most medical centers have, in order to protect their assets; and frankly, to provide more flexibility to generate some income. There are many other self-serving reasons, but essentially all of the money that is generated is reinvested in the care programs or capital improvements. So not only have hospitals incorporated, they have diversified some of their activities. I could describe the era that we are in as the era of the 'multi-hospital system'. It is predicted that in another fifteen years there will only be about 200-250 true health care centers or major hospitals in the country. My belief that this will occur is reinforced as I listen to my colleague from Eaton Rapids. You too may be reading in your own city papers about issues related to hospital mergers, the buying out of hospitals, or their affiliation. Academic medical centers are setting up a health care system of their own. The major hospital where acute inpatient care is given is the center; and from it all sorts of outreach programs are being developed which feed into the center. The reason for outreach programs is that most hospitals are underutilized and the competition for patients is very real. Thus hospitals or medical centers find themselves in the home care business, setting up outposts in a variety of settings, surgery centers, emergency centers, and so on. In Chicago in the past two months one major hospital has set up five outposts in various sections of the city. Competition is high because we have built so many so many resources we are not always able to fully use them. That is one area of change taking place. Another is the major emphasis of third party payor reimbursement on keeping patients out of hospitals. The result for us in nursing is to have much sicker patients with more complicating conditions, more complex surgery, and all provided within shorter hospital stays. Not only do these changes affect us, but they also impact on the visiting and community health nurses who also must deal with sicker group of patients in the home. These pressures are building up in the health care system moving us from one mode to another. Within this changing system then, how does nursing administration function?

The next decade for nursing in academic centers will hold many positive changes even though I am painting a rather dark picture particularly with regard to reimbursement. There may even be fulfillment of many of nursing's long-awaited goals. Something good can come out of adversity. In 1992, ten years from now, if I were to describe the characteristics of an academic medical center's nursing service department in terms of the delivery of nursing care I would highlight four elements:

1) First we have to have a different model for the practice of nursing. Nursing staff in hospitals must have an investment in the fact that patients are in the hospital. I refer to the possibility of profit sharing, if there is any profit. An alternative is a productivity model based on the care nurses provide.

2) Implied in this model is that the department has a system in place for identifying nursing needs, and for delivery of nursing care in relation to patient acuity. Costs for nursing service based on these identifiable and measurable factors are real; and income generated through these services is maintained for reinvestment and capital improvement for nursing. Currently there are many publications about reimbursement for nursing services. Some suggest that this can be done by just keeping some books on income and expense. This is not what I am talking about. I am talking about generating nursing's own funds for providing nursing care, with nursing departmental control over those funds. This issue is becoming more and more important because of pressure from third party payors who propose putting caps on how much will be paid. The government's approach to Medicare has changed with a new ruling that goes into effect next month. The government plans to reimburse on a cost per case basis. Everything that goes on in a patient care unit is to be buried in that cost per case. I emphasize that nursing administrators must be able to identify the need for and the result of their services, give the services dollar values so that the patient or third party payor may be justifiably billed. This is certainly not a very new notion. But there is now a growing movement to put this into place. This could be a vehicle to help support some of the activities that we talked about this morning in relation to the model for nursing ad-

ministration eduction. For example, as a nursing administrator if my department generates income then I could budget for a fellowship for a nursing administration resident, and be able to provide mentorship with good field experience for a graduate student so that the student could earn some income and be better able to afford that experience. I believe it would speed up the process of getting well-prepared nursing administrators out into the world of work. The practice model and building the foundation for reimbursement thus are interrelated. The generating of our own income would serve to support our practice, and support and improve the services we provide. Also, in this model we need a reward system for experience to show that we value clinical practice.

3) The third change occurring by 1992 is the issue of governance. Much has been written and countless workshops presented on the issue of governance, but it seems to me that nursing in academic centers will never truly have autonomy until we can define our practice, quantify it, provide some qualitative measures, translate that into dollar values, and finally ensure that nurses govern their own practice. I do not refer to a union model, but rather to a self-governance model complete with bylaws. We are already further advanced in that process than many people would have expected. Much work is being done so that in ten years most nursing services in academic centers will have some form of self government in place.

   Concurrent with self-governance there will be an increase in research and clinical activities to increase knowledge. These activities are necessary adjuncts to our model. If we generate funds from practice we have to know more about that practice and nurses in practice areas will be required to spend more time designing clinical studies and collaborating educators for clinical research.

4) Lastly, in this decade relationships between nurses in service settings and nurse educators will become blurred. Nursing education and nursing service will have developed a model for joint appointment and joint governance of their depart-

ments. There may be many activities that lead into this -- the ways education and service can already identify some collaborative projects, many of which are reported in the literature. This can only strengthen both service and education.

We will find a changing attitude in the next decade on the part of third party payors and the government in terms of reimbursement for nurse midwives and nurse practitioners. Because, in this health care system that I envision, nurse practitioners and clinical specialists will have a key role to play in many of the surgery centers, outposts, home care, and so forth. The increased acuity described earlier will increase the demand for well-prepared practitioners. The shortage of a year ago many be past, but I envision that the nurse pool for hospitals is going to level off. We are not seeing much growth in numbers of additional beds. Rather, we are seeing growth in new patient programs, new educational programs, new service programs of all types, and those factors will cause leveling off of requirements for hospital nurses, but cause increased demand for nurse specialists.

Nursing administration must be able to understand and justify who is giving patient care because, if nursing dollars are to be generated, decisions may have to be made in terms of whether you will have an R.N. staff or some other mix of nursing personnel. It may be that you will want fewer registered nurses, but they will be earning more money. Even if you only control part of the money, those are the kind of decisions that can be made. These four elements, the different models of practice; the identification of what nursing is and what it does; tied in with a system of self-governance and a method of generating its own funds; and support of our own programs through self-generated funds will become a reality in academic health centers in the next decade. The nurse administrator will be administering a broad range of services in addition to the hospital services. The model that Julia Lane presented this morning incorporates very well the needs of the nursing administrator for preparation to administer this kind of a program.

The impact of physicians in hospitals, although still very high, will begin to be altered. The over supply of physicians is producing a trend in which physicians and hospitals are on a collision course, particularly in the type of hospital that I represent. If the mode of medical practice is private or group, the same economic issues arise that arise between a nurse midwife and an OB/GYN physician. The physician sees the hospital as being in competition with him/her. In the next decade much emotional energy may be spent in wrestling with these issues. In order to survive, hospitals, such as I represent will also have to be out in the community providing the programs I have described; and they are in direct competition with the physician. So when you see the growth of physician-owned facilities in the community -- they're out doing their own marketing. This trend will be interesting to watch because it indicates that the power base is shifting due to changes in reimbursement policy. In this adverse time although many good things may come of it, I see physicians' influence in hospitals diminishing and not without considerable agony and blood-letting.

In looking at my crystal ball I believe this decade will see nursing, at least in the world of health science centers, emerge as a stronger professional group with a better understanding of its role in health care and more cost-effectiveness in terms of its practice. I notice the TV camera lights focused on us today. Ten years from now I hope someone from the University of Oklahoma will look at the TV tapes being made now to see if the predictions we have made today have really come to pass. The past is prologue to the future. We have come through a lot as a profession with each generation of nurses contributing to our present status and the impetus to move us ahead. So for those of you who may be here ten years from now I hope you'll do that and let those of us who participated today know what the outcome was.

Discussion

Question:

I wonder if Ms. Martel sees any movement of the physicians back into the hospital in management positions as they become over supplied in private practice.

Answer:

In some instances of hospital administration a decentralized model has been used with a triad or troika made up of a physician, an administrator, and a nurse as the administration team; and to be sure, there are certain institutions that will only tolerate a physician as the Chief Executive Officer; for example, Massachusetts General, and some hospitals in Chicago. There will certainly be a movement towards trying to be part of whatever is happening in hospitals. Physicians are likely to increase their participation in HMO's. Because of diminishing income they will need to be working in some of these outposts because that is where the patients are going to be.

Question:

I'd like to raise a question with regard to nursing practice generating it's own income. Right at this time nurses do not charge for their services and they generally are not reimbursed through third party payment. Are you recommending that nurses charge for individualized service and receive money for that service? If so, we will need to start utilizing computer technology to get this information on a computer so that nurses aren't constantly filling out those charge slips that Ms. Doxtader of Eaton Rapids spoke of earlier. What are some of your ideas about developing computer technology so that we could begin charging for individualized nursing services?

Answer:

I did not touch on that specifically in my administrative prophesying. However, there will certainly need to be a system in place for identifying units of nursing care delivered based on documented need. A computer is not essential to do that; but a computer would certainly facilitate it. A patient classification system, or a patient acuity system is needed in which cost can be established for each hour or unit of care and then transposed into the patient's bill. In this organized way the patient would pay for units of nursing service so that on the patient's bill there might be four or five line item costs, one of which would be nursing. In a academic center such as ours, I would like to see a line item charge for medical care too because, as you know, hospitals pay for residency training. On our hospital's budget it amounts to ten million dollars a year for house staff. However, it can be considered a pass-through as this cost is reimbursed by the federal government. At any rate I visualize nursing service as a separate charge, facilitated by the development of an integrated patient information system. The system would be available to personnel on the unit where the attending nurses can enter patient needs data, the units of care, and outcome observations into the computer.

Question:

The Gannons' book contains a copy of the form used at St. Luke's Hospital in Phoenix which covers all patient charges for nursing services. They have been in use for a number of years. The form is a very interesting one. It is a type of checklist on which the nurse checks off the kind of care that has been given. Certain of the items must be documented on the back of the sheet. Units are totaled every twenty-four hours and the sheet is then sent to a central "batching" area where the acuity level of that patient is computed and patient charges made out by acuity level. That sort of system is being worked on by several consulting firms so eventually it will become a computerized process.

Question:

There are several hospitals that are using systems for reimbursing nursing services. St. Luke's is a four hundred bed hospital in Phoenix. A sixty-five bed hospital has just started it in Cottage Grove, Oregon; and a third hospital is South Miami Hospital. Those are the ones that have put out the most information so that if you were thinking of doing this in your own hospital you could at least assess the situation. I believe those three hospitals are quite willing to share their information. However, to get back to the nurse practitioner and nurse midwifery there are three states that will reimburse for the nurse practitioner. One of MAIN's future programs might include a speaker such as Marilyn Goldwater who is a delegate to the Maryland legislature as well as a nurse who has been extremely active in moving nursing in that state. It was through her efforts that two bills -- one defining the scope of midwives and one defining nurse practitioners -- came to be. At last year's International Council of Nursing in Los Angeles one of the main thrusts was that nurses are the logical health provider for entry of people into the health care system. As doctors scurry to compete for a place in HMOs we may want to consider using nurses to bring patients into the health care system and into the hospital. here we are talking about economics and power, to acquire admitting privileges.

Question:

As a nurse educator I am watching with dismay the development of the clinical ladder in hospitals. I am wondering why we are choosing institutional certification over national certification. I predict that we are going to have some problem with institutional certification that we are currently having with attempts to articulate nursing's education system.

Answer:

In the testimony at the hearing for the National Commission on Nursing, and the IOM study we learned that we have no other tangible way of showing that we value clinical practice. So, when I talked about a reward system, some of it would be monetary, but also it would give recognition to the value of experience that a nurse learns as she grows and develops on the staff. Most of the nursing services that have a clinical ladder have established levels that are competency-based. It is not meant to replace the national certification program. It is an internal program which has no transportability, which is another important feature. The nurse administrators who have implemented a clinical ladder would probably give you the same answer: It is a mechanism for promotion and recognition of clinical nursing within the patient care arena.

Question:

I know that, but I think society or some group of nursing service administrators really need to look at this in a very objective way. I agree that it is crucial to recognize and reward clinical practice; but I also think, by the same token, that we are doing a major disservice to nursing when we do not recognize that in certain cases, certification for nursing means nothing.

Answer:

There is ANA certification, Critical Care certification, and Operating Room certification which are rewarded in the Veterans Administration by several step advancements in salary.

Question:

But, only in the Veterans Administration system.

Answer:

The V.A. also gives certification for holding office in a national professional organization. I mean we give financial reward, and that is part of the regulation we are talking about, is it not?

Question:

Nevertheless, one way or another I think that in nursing we really need to look at the systems we are starting and attempting to implement. In many ways the clinical ladder looks like some kind of certification process. That is the point I wish to make. We need to take care not to weaken our credentialing system in nursing.

Question:

Carolyne Davis at the ANA Convention, made it very clear that under the Medicare regulations, Medicare will reimburse directly those midwives who can legally practice in the state where they work. We are talking here as if this is not possible. It is possible. Medicare will pay for it. We just have to do something in the states to facilitate it. Nurse practitioners are reimbursed under Medicare and this will increase according to Dr. Davis as you heard in her predictions at that convention. All we need to do is facilitate it locally.

Answer:

That relates to the recommendation to invite Marilyn Goldwater to present at a MAIN program. She facilitated this process in Maryland.

Question:

Adding a point to that, we got reimbursement for nursing included in the Wayne State University Blue Cross /Blue Shield Plan, and the way we did it was simply that we were the purchasers of the plan and we wanted this as one of our rights of freedom of choice. But what we did was provide language that Blue Cross/Blue Shield could live with. They would not set themselves up for reimbursing all R.N.'s in the state of Michigan, until we said reimbursement would only be allowed for health care providers practicing within their legal scope of practice, offering a reimbursable service under that plan. So, in the case where the Registered Nurse was the health care provider, she had to have a MSN Degree and be certified by an appropriate certifying agency such as the American Nurses' Association, or the College of Nurse Midwives. The Blue Cross/Blue Shield agreed to that without a quibble.

PROBLEMS OF NURSING SERVICE FOR WHICH ADMINISTRATIVE CONSULTATION IS COMMONLY SOUGHT; AND SUGGESTIONS FOR THEIR RESOLUTION

by Lyndsey Stone

The first part of my topic, that of "problems", is easily addressed because all major problems are usually "people problems". That is, people's perceptions, action or inaction, interpretation or misinterpretation of policies (or their absence) creates disequilibrium. When participants in an organization are not operating in a synchronized manner, and their subsystems are no longer in balance, some particular subsystems (a service or department) is usually identified as the problem. This "burr under the corporate saddle" generates the stimulus to seek consultation.

Since Nursing and Financial Services have a disproportionate effect upon the health of the organization, when dysfunctional behavior occurs in either of these departments, the chief executive of the hospital is usually concerned. While the Financial Services Department is crucial for managing the capital for continuity of the operation, nursing is critical because of its large size, expense, and significance for income generation. If the nursing subsystem is not working well, the bed occupancy rate may be lowered dramatically. For example, poor quality nursing lessens the willingness of physicians to admit patients. The physician is the hospital's primary consumer, i.e., patients do not admit themselves to hospitals, hospitals do not admit patients, only licensed physicians and dentists may have admitting privileges and physicians won't use a facility that is poorly staffed or expensively staffed by agency personnel. The initial result of nursing quality problems is closed beds and reduced hospital revenue. In the long run, beds become more expensive and revenue is still lower than it should be, sometimes threatening the hospital's survival.

The decision to request consultative services in nursing is usually made by the chief executive officer, although in some cases the nursing administrator will independently request such services. Let us look at some reasons for the call for help. In the past three years, we at Presbyterian Hospital and IHP have addressed these problems internally or as consultants to other hospitals:

1) Problems in nursing leadership and in management of nursing operations,

2) Organization climate and morale problems in nursing,

3) Conflict between nursing and physicians,

4) Consumer complaints related to quality of nursing care, sometimes conveyed by administrators and physicians.

Of course, specialty service consultation occurs; for example, the operating room emergency room or ambulatory services may require restructuring of lines of authority and responsibility; that is, the definition of "turf" through clearer structure, and assistance in clarifying expectations by and toward the hospital as a whole. Such activities, initiated through consultation, often resolve people problems by changing both perceptions and interactions of individuals. In operating rooms, ambulatory services, and emergency service, the "crisis" orientation and sheer sense of urgency of the parties escalates conflict unless specific mechanisms for its resolution are utilized rapidly. Consultation provides an outside perspective, quick turnaround time and concrete short and long term suggestions for change.

Educational needs assessment and program development consultation is expanding because nurse administrators are increasingly recognizing their broader responsibilities in career development including clinical levels of practice. A related growth area for consultation is special programs, including the nurse extern, nursing internship, new graduate and bicultural training.

More technical consultation studies occur, such as JCAH/Medicare survey studies, staffing, patient acuity, and classification surveys. These are necessary only occasionally, are technical in nature, and require expertise which may not be available on a regular basis in many hospitals. Thus, consultants may help to fill a short run staffing gap.

Hospital management surveys are a separate category, but one in which nursing must participate. Institutional assessment is indicated if there are overall organization problems, or if it is part of assessment within a management contract proposal. Frequently, the hospital management survey is part of a strategic and long range planning study which examines alternative future scenarios for the hospital's development.

It is obvious from these examples that there is a very broad range of consultative services which involve nursing administration. Consultative services can be simple to design and implement; for example, the design and implementation of a quality assurance program for which concrete, well-defined objectives are already provided for the consultants. But consultation can also be complex with unpredictable outcomes, regardless of the quality of the consultants employed. For example, physician/nurse conflict is highly subjective, emotionally intense with an extensive history and probable polarization of the parties. Physician/nurse conflicts can and have destroyed health care institutions, despite the most able consultation. Too frequently, by the time consultants are brought in, the problem has escalated beyond the point where the parties are willing to resolve their differences. Thus the situation may be irrevocably structured for failure.

At this point, it would be useful for me to describe a few situations in which we consulted in nursing administration for other hospitals. The flavor of reality may shed some light on the issue of problem resolution, which is an important part of today's topic. The cases described all have a common thread among them -- that of consulting method. The method was analytic and painfully honest. The basic question asked was this one: What are the options available to the parties to resolve the basic organizational problem?

Case No. 1: Nursing Director's Job on the Line

Confrontations were intrinsic to this case from the outset. The hospital administrator wanted to fire the nursing director for incompetence, but asked first for consultation to determine whether this was the appropriate action. A sequence of meetings was held with administrators and nurses. I told the nursing director quite bluntly that "administration thinks you're no good and should be fired. I don't know whether it is true or not; but nevertheless I'll have to make a recommendation. You have long years of experience, which is positive, but you're very hostile and that's negative". The crisis in nurse /administrator relations was a consequence of physician dissatisfaction with nursing care, and with the attitude of the nursing director. The hospital was being managed by a new organization, although it was an old facility with an old nursing director and long term staff members who were "living the past". Old management and nurses distrusted the new management.

The sequence of interviews with other administrators and nurses was completed with a visit to the nursing director. She was told what the people around here thought about her. What she needed to do to retain her position was fully described. Doubts were expressed about her ability to completely change her attitudes and behaviors, but we also indicated how difficult it would be to replace her and how much it mattered to the community to have high quality nursing and physician compatibility in this isolated rural community.

This was the first time that the nursing director was dramatically confronted with her behavior and the shock was sufficient to arouse her action. The nursing administrator connected her hostility to its effect on the hospital, other nurses and the community. The nursing director and the hospital administrator were told what each thought of the other. Then they and the consultant met to plan their future relationship. The administrator wanted the nursing director to make decisions; he agreed to live with her mistakes in the learning process and not to expect perfection. She agreed to build a positive relationship with the physicians.

It is now three years later. The nursing director is still in her position and highly successful. After the initial consultation, she called weekly for advice for about three months and has since been self-sustaining. I concluded that the nursing director was sufficiently motivated to change and was flexible in her character. Once she connected her negative attitudes and behaviors to their consequences, this nursing director was horrified enough to alter her actions, improving the organization climate and relations with physicians and administrators.

Case No. 2: Physician and Nurse at the OK Corral

In this rural hospital, the same physicians had practiced for thirty-five years and the equally conservative nurses had worked there for over twenty years. Aides were employed for twenty-five years or more. There was no turnover; although pay was low, morale was high.

The equilibrium of this situation was upset by the introduction of two osteopathic physicians who were young, aggressive and concerned with practicing modern medicine. There was immediate conflict! The new physicians wrote extensive orders which the nurses had never heard of and didn't know what to do with. New tests, IVs, drugs piggybacking on IVs, patient monitors and modern equipment was requested.

When three young BSN nurses from the big city arrived, they naturally affiliated informally with the young physicians. The new nurses reported the activities of the old physicians to the young physicians. The old nurses complained about the new physicians to the old physicians. A new hospital administrator entered the scene. Then, a catalytic event occurred: a young physician insisted that the old nursing director be fired.

When the old director of nursing was fired, the old nurses walked out. Charges were aired in the community and in the local newspaper. The entire town was divided and the parties could not be brought together. The consultants interviewed well over three hundred people, including the physicians and nurses involved, administrators and members of the community. The parties were told what needed to be done and the consultants' bill was paid, however, their advice was disregarded. For resolution to occur, it would have been necessary for the old and new physicians to work with the old and new nurses in patient coverage. The parties were simply too polarized by the time that consultation occurred for negotation on the issues.

The consultants had advised first, that the hospital be managed on a contractual basis by some other organization. Second, we conveyed that the old physicians should be publicly thanked for their long years of service to the community. Third, we recommended that the old (fired) diector of nursing receive a public apology circulated through the mass media with thanks for her long service.

The moral of the story, of course, is that the physician is the prime consumer of nursing services and nurses cannot dictate hospital policies. The long term effect of this conflict is low bed occupancy and high cost per bed in the hospital. The old physicians and their patients now commute to another and more distant facility.

Case No. 3: Complications of a Management Survey

A proposal was underway to manage a hospital which currently had no nursing director. Nursing consultants involved in that project were called in to advise hospital management separately after the demotion of the nursing director to an inservice education and quality assurance position. As we will see, the characteristics of the demoted director were central to the administrative action taken against her.

The former nursing director was demoted for mismanagement of funds. She had sent six LPNs and nurse techs to school and arranged their schedules accordingly. They were paid for a forty hour week, and some of their time had been spent in job-related educational experiences. A paltry amount of money was involved and the hospital was well staffed by these people, including weekend duty. They had further committed themselves to two or three years at the hospital in exchange for educational opportunity. This was at the height of the nursing shortage in late 1979!

Community politics surfaced as the basic problem. The demoted director of nursing was married to a previous mayor of the town. His political rival and members of that faction were influential members of the hospital's board of directors. After interviewing everybody concerned, we recommended that the old director of nursing be returned to her position and commended for her innovative efforts to retain nurses. Within six months the advice was taken, and now, several years later, this woman is recognized throughout the state as a capable and farsighted nursing administrator.

At this point it should be clear that management problems in nursing are difficult to solve and that some are impossible by the time consultation is sought. Suggestions for the resolution of a particular problem in a specific hospital just can't be developed along the "cookbook" approach. Each situation is unique and must be examined in terms of the rights, responsibilities and feelings of the parties as well as the stage of development of the problem. The literature supports this conclusion.

What can be said that is helpful to nurse administrators facing common problems and desiring consultation? First, the nursing administrator ought to view the organization as a culture and find consultants with equally broad perspectives on organizational life. Culture is important because it is "a system of informal rules that spell out how people are to behave most of the time...a strong culture enables people to feel better about what they do, so they are more likely to work harder" (Deal and Kennedy, 1982, pp. 15-16). The workplace mediates behavior, and its environment, values, heroes, rites and rituals and cultural networks communicate what's really going on, how things get done and what kind of behavior is rewarded. Each of the three cases described in this presentation occurred in a different cultural context. The weakest culture, the Physicians and Nurses at the OK Corral, was a failure in implementation of consultation advice, because a frail culture lacking in cohesion was unable to deal with the problems well enough to regenerate the culture. In the case of Complications of a Management Survey, external environmental problems were readily dealt with in a secure cultural context where members were to some extent protected; for example, the director of nursing was demoted rather than fired for mismanagement of funds, suggesting latent strength within the culture. The Nursing Director's Job on the Line revealed a culture where there was considerable congruence among expectations, but the focal individuals needed external assistance for behavioral feedback.

The extent to which consultation is successful (assuming that competent consultants are hired) is a consequence of the severity of the conflict in relation to the strength of the culture. A strong culture can survive a severe conflict which is intensive and extensive, provided that catalysts are available to bring the parties together to build a new equilibrium. But a weak culture which may sustain itself when lesser problems arise cannot survive because it lacks the "glue" which holds work units and their members together during stressful periods.

We can anticipate a geometric increase in trauma for nursing administration in the next decade. Throughout our society, organizations function in complex enviroments, with accelerated rates of social, economic and cultural change. Markets are increasingly competitive. Hospitals and nursing departments are dealing with a changed workforce, one that is richer, better educated, more independent and very attracted to the revolution in electronics and cell technology. Trauma is associated with the clash of the old and the new, as the three cases presented here illustrated.

We can expect that consultants will be the samurai of the future, alleviating stress, providing new criteria for management decision-making, and sorting out the unique elements in each nursing service problem. In brief, there is an organizational revolution going on and nursing is being dragged into it kicking and screaming. Our control of the future of the profession rests with our ability to effectively utilize internal and external resources at early stages of problem finding, while bearing in mind changes in American society as a whole.

The ultimate resolution to the common problems in nursing lies in building a strong culture within nursing administration and in the hospital as a whole. The characteristics of a strong culture are as follows:

1) Values, which are the "bedrock of any corporate culture...values provide a sense of common direction for all employees and guidelines for their day-to-day behavior...often (organizations) succeed because their employees can identify, embrace and act on the values of the organization" (Deal and Kennedy, 1983, p. 21). Values indicate what managers think are important to emphasize and this message is carried informally throughout the enterprise.

2) Heroes - "personify...values and epitomize the strength of the organization". Heroes have enormous impact as role models and by setting standards, preserving what is special about the organization, symbolizing the organization to the outside world and of course, motivating employees.

3) Rites and Rituals tells new employees "the way we do things around here", and under the assumption that "unless you tell people what you want them to do and how you want them to do it, you have no right to expect them to infer, by some mysterious alchemic process, just what you had in mind" (Deal and Kennedy, 1983, p. 37, 59).

4) Communication is largely an informal process which can be described as "working the cultureal network"; the grapevine that integrates the company without respect for hierarchy. By cultivating the network, an administrator can know what is going on and its potential importance long before formal messages pass among participants about problems and opportunities.

Now how does a consultant help a hospital build its culture?

For the consultant, organizational diagnosis (Levinson, 1972, p. 6) is the most significant single step that is undertaken. An organizational diagnosis is an hypothesis based upon collection of data relevant to a problem area. The hypothesis links prior conditions with future actions, so that the effects of alternative courses of action to remedy the problem can be predicted. Learning to read cultures is essential for diagnostic purposes. How then, does one read a culture? First, you study the physical setting. Second, you read what the organization says about itself. For example, annual reports, memos, policies, etc. Third, you note how the company greets newcomers (including consultants). Fourth, you interview members of the organization. Fifth, you observe the way people work, how they spend their time. Anecdotes and stories passed along the cultural network are often very revealing (Deal and Kennedy, 1983, pp. 129-135).

When a culture is in trouble, the signs are abundant and easily viewed by the outsider. There may not be clearcut values of beliefs about causal factors in organizational success or what is most important among these factors. Heroes may be disruptive and day-to-day rituals disorganized or contradictory, with people and departments working at cross-purposes. The worst symptoms of cultural malaise are these:

1) An inward focus, isolating the organization or some part of it from the real world;

2) A short term focus without much time spent planning for the long run;

3) Morale problems, including high turnover;

4) Fragmented or inconsistent standards so that there is no real "cultural mesh";

5) Emotional outbursts indicating fear and anger.

Balancing the legitimate differences of subcultures with the legitimate and desirable elements of an organization's culture as a whole is one the trickiest parts of diagnosing and managing culture. At a minimum, managers must know what is happening in existing subcultures and be alert to new subcultures that may emerge..."cultural diagnoses will give managers a fix on the state of the culture, particularly whether it is weak or strong, focused or fragmented. Given this fix, a manager can then sharpen the focus of his or her managerial efforts" (Deal and Kennedy, 1983, 00. 133-139).

There are many lessons for nursing administrators in this dialogue on corporate culture. First, problems in nursing service are generally easier to avoid than to solve. Second, there is a blueprint available for a strong culture but not resolution of common problems in unique organizational situations. Third, the consultation process does not assure the nursing or the hospital administration of a positive outcome. The strength or weakness of the culture in relation to the history, type and severity of the problem is the final determinant of success of failure. In brief, the most successful nursing administrators are those futurists who utilize both internal staff and external consultants to help them transit a period of rapid cultural change affecting the equilibrium of all hospitals, and within those hospitals, of all nurses and administrators.

The danger lies in the nursing profession's past fondness for micro rather than macro perspectives on the administrative process. By monitoring the comfortable details of routine administrative functions, it's possible to indulge in the illusion of a stable work world. When this occurs, nursing becomes isolated from the behavioral problems that inevitably surface among physicians, nurses, administrators, patients, and communities. The untidy, often troublesome but ultimately rewarding experience of membership in an organization with a strong culture is difficult to describe. But it is heady, and can be described as "the champagne of daily work life". It is worth aiming for with the help of internal staff in collaboration with external consultants in both specialized and general administrative areas.

It is my hope that the profession of nursing will be on the frontier of organizational change, building the strong cultures necessary for success in the health care industry. For nursing to maintain a cutting edge in the future of hospital management, the primary concern must be organizational effectiveness. Organizational effectiveness can be defined as "the ability to adapt future strategy and behavior to environmental change and to optimize the contribution of the organization's human resources" (Turner, 1982, p. 128).

REFERENCES

1. Deal, Terrence E. and Kennedy, Allan A., *Corporate Cultures: The Rites and Rituals of Corporate Life*. Reading, Mass: Addison-Wesley Publishing Co., 1982, pp. 15-16.

2. Levinson, Harry, *Organizational Diagnosis*. Cambridge, Mass: Harvard University Press, 1972, p. 6

3. Turner, Arthur N., "Consulting is More Than Giving Advice". *Harvard Business Review*, September/October 1982, p. 128.

Discussion

Question:

What do you think would happen if other people could admit patients to the hospital thus breaking up the power structure? With the excess of beds and excess of physicians, won't things get worse for nursing unless the hospital can find a way of not having to be so dependant upon physicians?

Answer:

Are you addressing the question of nurse practitioners having admitting privileges?

Question:

There could be other kinds of services such as nursing clinics to which people could come for health care, increasing the use of hospitals facilities for health promotion. Statements that you made about the young physicians infer that all their activities did not improve health. We are going to have to face up to the fact that we've got a pervasive problem here and nursing is getting caught in the middle between physicians and administration.

Answer:

Nursing will be caught in the middle as long as we are not able to make ourselves and our practice understood, so that the physician will understand it and us. The dialogue I have with physicians in the hospital is usually that they really do not understand nursing, do not understand what nursing does. They say: "We no longer have input into nursing education. These young nurses are asking me questions they have no right to ask. I am the doctor, I prescribe this medication, why should they challenge it?" And the aggression, not the assertiveness, but the aggression of the new graduate today is doing much harm to the nursing profession.

Here is an example: Complaints are received from a given physician about calls he receives at night about his patients in the intensive care unit. Then me makes comparison with another nurse who, when she calls him, tells him what she is doing. He said: "I know that nurse, and I can trust her. I know what she can do, and when she talks to me I believe her. Those other people are just voices on the phone or new faces, I have not idea what they can or what they cannot do, and I don't trust them". Your question is too complex. I think it gets into the socialization of nursing students. You have to look at what they are taught in schools, what is the nurse's perception of the role in the hospital in the real world. What it should be and what it is are two different things.

Question:

I don't know whether you recognize me or not, but I was one of the nurses at the OK Corral.

Answer:

I know, yes, and you are now the Nursing Director there.

Question:

And, I wanted to say that we are still alive and well in our community. I think our biggest conflict was change. I thought you did a good job of presenting our story, but it came down to the old versus the new and there wasn't any cooperation between them. I think the same outcome would have come eventually. The process that we used to get it was wrong.

Answer:

Did you see the consultants as being useful even though they were ignored? Was it a useful experience with nursing to have them in?

Question:

Oh, I think so, yes. Let me say though, that the consultants didn't please anybody. They left everybody dissatisfied a little bit, but they still gave everybody a pat on the back. Everybody came away saying, well I did do some things right, but maybe I didn't handle something else very well. And, I think that the recommendations you made are still being referred to.

Question:

To what extent do hospitals use a mission statement to guide their organizational structure and daily operations, and secondly, I would like to know to what extent do they involve the sub-units at the hospital in the participation of it's development and it's daily application?

Answer:

All hospitals have a mission statement. They are required to have a mission statement which is a broad overview of the direction, goals, philosophy of the hospital, Board of Trustees and it's medical staff. What we use to direct patient care (the second part of your question) I believe, are the annual goals and objectives that we develop based upon the broad outline of the mission statement. The mission of the hospital is stated very broadly, and, annually, as part of the budget process, we have to develop corporate goals and objectives. The subsystems, including nursing, and all the different subsystems in the hospital, address the corporate goals, and develop their goals based upon the goals and objectives of the organization.

Question:

I am from Wisconsin in a 405 bed hospital outside of Milwaukee and I would like to share with the group one of the things that we have done as far as starting nurse run clinics, as a way of generating revenue. We looked at our strengths and tried to see where we felt we could have the most influence. At that point in time we found we had the most influence in psychiatry. We have an adolescent psychiatric unit and an adult unit, and we have four clinical specialists who are in psychiatry under contract who are running nurse clinics which do not depend upon physician admission, and which are generating revenue for the hospital. Our next focus is going to be OB. We plan to have nurse run clinics in OB. So, you need to look around to see where your strengths are and match them to what the community wants by doing some assessment of your community. It is slow, but it is moving, and, I think, very positive.

Answer:

I think the key words there are "slow, but it is moving". We are looking, for instance in Oklahoma, at the hospice concept. When it was first addressed, two years ago up front, there was really no physician support for hospice services. The physician director of the program was an oncologist. Attitudes are changing now and I believe hospice care in this community may be available in the next year or so. But the clinics are, as you say, one area where nurses can practice. A lot depends on the state one practices in, --- whether physician supervision is required, and whether physicians are required to write the orders in order that reimbursement is available. There may very well be fifty different sets of rules by which to play the game.

INTRODUCTION TO CAUCUS SESSIONS

Caucus group A was facilitated by Phyllis Drennan on "Qualities and Characteristics of Effective Nursing Administration". Questions were examined such as: What constitutes effective nursing administration? and What elements must be present to provide safe health promotion and appropriate care to patients?

Leaders of Caucus group B was June Liggins on "Knowledge and Experience Needed to Prepare Nursing Administrators." Subtopics under that heading were: What components of curriculum or course content and supervised experience should be included in academic and clinical programs? and How would this content help to fulfill the American Society of Nursing Service Administrators or ANA's criteria for recognition and certification of nurse administrators?

Caucus group C was led by Mary Morris, and focussed on: "Logistics, strategies, and access related to implementation of a regional program in nursing administration". More specifically it examined: What are the ways the region can best implement such a program as part of legitimate academic credit programs in established educational institutions?

Caucus group D was led by Brenda Ernst. The topic was: " People and resources in the region likely to be helpful", focussing on questions such as: What are the people and where are the places to find expertise, programs, residencies, etc. already in operation?

REPORTS FROM THE CAUCUS GROUPS

CAUCUS GROUP A: Qualities and Characteristics of Effective Nursing Administration

First of all I would like to thank the members of Group A for their participation yesterday as well as Phyllis Drennan, our leader. She did a very good job, I thought. Mary Wakefield-Fisher has told you the responsibility of Caucus Group A was to address the question: "What constitutes effective nursing administration?" and "What elements must be present to provide safe, health-promoting, and appropriate care for patients?" We seemed to have several recurring thoughts yesterday, and this will be a summation of our group's thoughts. We discussed effectiveness, and whether it is the person, the position, or the process that mattered most. We decided it was the process. And this process includes nursing administrators supporting the mission of the organization and influencing this direction. Recognizing both intra- and extra-institutional variables such as professional standards, regulatory agencies, voluntary accreditations, and the use of management principles to integrate the purpose and goals of nursing with the mission of the organization.

An important point brought out in Caucus A was that process effectiveness needs to be evaluated, utilizing variables of expectations, tasks performed, and timeframes. The group then identified the need for more research in nursing administration. We also identified variables in nursing administration such as non-nursing administrators, and what makes nurses unique in this role. It was suggested that it is our body of knowledge, our nursing data, the current trends in nursing, nursing theory, and research in nursing that makes us unique.

We then identified a checklist of nursing service administrators' responsibilities to include: planning, administrating, supervising, coordinating, recording, and budgeting. The parallel was made that if nursing administrators are prepared in business schools today then why not the nurse educator being prepared in schools of education. We did support Dr. Lane's paper and felt that the technical, human, and conceptual skills are essential to this position. And, finally we recommend a continuing collaboration of service and education in defining the unique body of knowledge for nursing administration.

In review, what type of administration is needed and what constitutes effective nursing administration? In order to have an intended outcome plan and produce a desired impression, understand the process, and understand human relations, you must possess knowledge of the mission and goals of your organization, knowledge of standards and regulations, and use of managerial principles in a supporting climate for nursing practice. Ours must be an evaluated administration. We support the need to continue nursing administration research. We need to set the direction for how nursing administrators will be prepared in the future.

To be effective nursing administrators we must plan our time and our direction toward planned outcomes. I hope that we will continue to share our strategies in meetings like this.

CAUCUS GROUP B: Knowledge and Experience Needed to Prepare Nurse Administrators

I wish that I could report to you that we had a concensus of opinion, but I think that that is not a fair statement, so I will tell you some of the ideas that the group came up with in terms of components for a core curriculum for nursing administrators. One of the givens that we assumed at the beginning was that we were dealing with the graduate level and that people coming into this proposed program would have BSN preparation, with two years of clinical experience prior to entering. Also, we assumed that they would have knowledge of computers, or have what is termed "computer literacy". Incidentally we, as a group, supported most components of Dr. Lane's model. We talked about the technical elements described in that model and included budget management, finance, legislative process, economics, negotiation skills, gamesmanship, and salesmanship.

The area of the clinical component, of course, after the morning session, was still a lively discussion in the afternoon, but in the afternoon we were able to partially agree, if not totally, that it was not necessary for nursing administrators to have the same kind of clinical emphasis that currently exists in the programs where there are clinical specialist experiences. Instead, we determined that nursing administrators needed to understand how to utilize the people coming out of those programs. We need to address, in our nursing administration program, within the clinical component, the clinical issues that these people are dealing with and how to use the clinical specialist, the practitioner, or other nurse specialist in our setting. We need to address quality assurance, to understand what clinical specialists have been taught, and rather than place the emphasis on the actual skills in the program, we need to teach how to administer the skills of others. Not everyone in the group agreed with that, but there seemed to be more consensus than there had been in the morning discussion.

The organization design, we think is an important component of our curriculum design and we want some emphasis on team-building along with new techniques for the delivery of information needed to make use of other resources in the institution.

Under the area of personnel we felt that we needed to take a self-inventory of our style and skills and articulate these with the people that we are managing. We need to learn something about leadership theory, legalities in handling personnel, all the legislation that impacts on patient care services, and certainly we would include labor relations.

The next area that needed to be included in the curriculum would be communication styles. We need some help, perhaps in public speaking and also in the area of adult learning. We felt that research was important and that too must be included in the core curriculum.

Some of the other areas that were discussed were: how to handle change, and how to plan programs and evaluate them. It would be important for nurse administrators to have the opportunity for a residency, internship, or practicum, whatever it is labelled. Nursing administrators need to have some tools to learn how to be flexible, and to maintain flexibility in a changing climate. We talked about the flexibility needed in the proposed program, the availability of this program to students on weekends, Friday night, Saturday and Sunday, with satellite programs rather than the traditional daytime or evening type class that we have now. We support the ANA and ASNSA statements on expectations for the nursing administrator.

Another final element that we thought was very important for our model curriculum was the historical perspectives in nursing and nursing administration.

CAUCUS GROUP C: Strategies to Implement Academic Credit Programs for Nursing Administrators

A curriculum model in nursing administration could be a planned, structured educational design for preparing nursing administrators. This design would be unique in the sense that it would be available to any midwest university setting wishing to use it. It could enhance and /or supplement already existing educational programs. It is one creative way of extending teacher and program resources to more people. It would be accessible to universities and/or students who would ordinarily not have access to it. MAIN's goal in offering a curriculum design would be to suggest academic units of instruction and skills practice sessions that would eventually lead to a Masters of Science in Nursing Administration. Institutions of higher education could accept MAIN's entire model or could use parts of MAIN's curriculum in their own programs.

The Content

To further develop the curriculum content of MAIN's program design--a curriculum committee or council could be formed consisting of representative faculty from MAIN educational and service agencies. The program design could be a master blueprint with futuristic projections of content and process in nursing administration, and have built-in quality control provisions. The program design could be broken into specific tracks of content so that specified units could be fitted into already existing university programs leading to the Masters of Science Degree in Nursing Administration. Several issues will have to be dealt with then shaping such a curriculum design:

> Individual universities would always decide whether to accept one or more of MAIN's suggested program units for transfer credits, and how many of such credits can be allowed. There are other dilemmas: trusting educators outside their universities to teach appropriate content without feat that the integrity of their own programs would be sacrificied or jeoparidized; territorial concerns regarding an open course design vs student and/or nursing agency administrative

needs. Individual universities would need to consider how rigid and structured their programs are and to consider flexible options to meet the administrative learning needs of students and agencies. A MAIN model could provide these flexible options. Intrastate and interstate academic administrative agreements are a major concern. For example in Tulsa, Oklahoma, two years were needed to iron out the details of the UCAT system for graduate education. Accreditation issues are also a concern. Standardization of program content could decrease this concern, but then on the other hand standardization might sacrifice creativity, flexibility and impose dogmatic standards. Nurse educators and administrators need to remain goal-focused on MAIN intent. An interdisciplinary approach can be taken to the teaching of nursing administrative content. Doctorally prepared faculty within the disciplines of nursing, business, and the social and behavioral sciences can be used as resources in implementing the proposed curriculum design. Rotating traveling faculty on an exchange schedule could be used to insure that the existing limited supply of nursing faculty talent be used optimally. MAIN sub-committees could be used to inventory faculty talent and to function as talent scouts in the recruiting of able and willing faculty.

Place - The Location of Instruction

Outreach locations throughout the midwest could be targeted as critical locales for specific program units. Examples might include university settings, nursing practice settings, or in general public community settings. Criteria for settings can deal with convenience, feasibility and accessibility. Traveling, location, rotation, type of setting, and schedules would be considered.

Time

A variety of time plans could be structured such as interim semesters, weekends, off-season; concentrated periods of time can be used. Time-concentrated learning may be more effective and helpful than traditional learning time for working nurses, for nurses with specific household, parenting or civic responsibilities.

Money

MAIN will need to market the plan in order to insure successful implementation. Money is needed for all levels of planning, implementation, and evaluation. The tapping of resources of private corporations producing health related commodities might be one source of funds. A small portion of student enrollment fees could be allocated for MAIN. Available willing faculty and the fees they charge plus the fees MAIN charges and fees individual universities charge would probably adjust to the principles of supply demand.

Strategies for implementing a regional curriculum model must include grappling with the nature of graduate nursing education in which both the teaching of content and the socialization of professional nurses are applied to the teaching of administration.

Tools

Tools for implementing content can include TV programming, self study modular learning, strong academic advising, use of micro-computer, video, and tele-communication technology by way of appropriately-educated preceptor faculty in nursing practice situations. Taped interactions in combination with written feedback by students and faculty regarding the concerns of each about the content and process of nursing administration learning can be used.

Tools for enhancing professional socialization can also include:

a) the mentor-mentee relationship to ingrain professional role behaviors. The model might set up guidelines for this;

b) the administrative preceptor program with predetermined criteria;

c) creating and networking systems;

d) setting up cluster situations in specific geographic locales so that students and faculty and administrators in that particular area can share their ideas, feelings, experiences and concerns with each other. This may take the form of seminars, panels, groups, etc.;

e) opportunities for communal experience between faculty, nursing administrators and students may be suggested as one way to enhance vicarious learning and professional identification; and

f) students need to be encouraged to make their own professional social arrangements on their own level.

CAUCUS GROUP D: Regional Resources for Nursing Administration Development

Caucus group D examined the people and places having expertise, programs, residencies, and so forth, that are already operating. We had a helpful piece of information prepared by MAIN of the NLN accredited academic nursing administration programs in the Midwest. So the first thing we did was to go through this list. The members of the group pointed out that some of the programs were not described correctly. There were seventeen programs listed at the masters level which have either a specialized nursing administration masters or functional option. Through our discussion we agreed that there are probably at least three or four more that were not on the list and several which are post-masters which are not listed because they are not NLN accredited. We summarized three concerns:

1) That it would be very helpful if MAIN could get together a more accurate list of the educational institutions offering these programs in nursing administration, and that would mean some surveying of the institutions, and not just using the NLN books that list those;

2) Obviously we need to have access to those which are post-masters which you cannot get through NLN publications and that will take some surveying also;

3) We were intrigued with the description taken from the actual NLN book of what these programs are and they range from nursing administration to supervision, to management, to leadership, and we were not really sure what these different terms meant. We thought it would be very helpful when we talk in this framework if MAIN would agree to use the term nursing administration in a generic sense. It would also be very helpful, within MAIN's

thirteen states, if we could come to an agreement on a taxonomy for the lower levels of nursing administration and supervision. One member suggested that ANA has done this through its Commission on Nursing Services. Such a taxonomy would help us to agree when we are talking about levels of administration and supervision.

Then we discussed the issue of how to identify resources in the service settings, e.g. the nursing administrators who would be mentors or teachers. And, instead of deciding who these people are in the region, we looked at the process of how one would go about identifying them. We did not come up with any names, but we struggled with how does one know, -- how would MAIN know where there are qualified nursing administrators to put students with. What credentials are desirable? We suggested nine different ways to give guidance in selecting appropriate mentors for residencies. They are not absolute, and they don't all have to be met before someone would be considered appropriate, and some are fairly controversial, as follows:

1) The nursing service administrator in the field is certified for advanced nursing administration and has passed a certification process either by ANA or the American Society of Nursing Service Administrators of AHA.

2) The nursing service administrator has a joint appointment in a school of nursing and,

3) holds a masters degree in nursing. Many people in the group feel strongly that only a masters-prepared nursing service administrator in a hospital should be a mentor for a masters level student. Others disagree, stating that someone who had been innovative in hospital nursing administration would be appropriate.

4) The Nursing Service Administrator has demonstrated high quality in job performance, but defining "high quality" may be difficult.

5) These people are located through networking, through this organization, and through other professional associations;

6) In the same way, we locate the good places to send students.

7) Those institutions which seem to market nursing services;

8) Those institutions in which nurses seem to publish a lot. This sometimes gives you a clue about desirable sites for graduate student learning.

9) The nursing administrator has a willingness to serve as mentor.

SUMMARY AND RESPONSE TO CAUCUS GROUP REPORTS

by Rozella Schlotfeldt

We are now looking at ways to share our Midwestern talents more widely than they have been shared before. I commend the caucus groups and reporters for extracting information which is so useful to all of us.

The first Caucus, "Qualities and Characteristics of Effective Administration" emphasized the need for research. I doubt very much if there are many persons who would consider that to be a controversial subject. Another of their recommendations agreed with our task force recommendation that there be collaboration between nursing education and nursing service personnel to develop content for the program. The notion of the task force was that there would be collaboration among persons now offering graduate study in nursing administration and the opportunity for them to collaborate with their counterparts in service. Some of them hold joint appointments in service and education. Certainly the list of content, will be a remarkably good resource for those programs to be jointly developed by persons in service and education.

The endorsement of nurses relative to using resources appropriately and economically reinforces the assumptions made by the task force members who attempted to serve this total group by suggesting a program such as we did suggest.

The second caucus group talked about knowledge and experience to prepare nursing administrators. We have had a tendency to think about preparation of nursing service administrators throughout the program. In a good many higher education institutions there is the belief that there is core content in nursing administration that would be equally useful for persons serving in positions of responsibility in education as well as in service. From the nodding heads, I gather there is general agreement about that. There are certainly differences, nevertheless, when one is talking about content that is appropriate for nursing administrators. I can understand the emphasis on opportunities for education in nursing service because there are external controls that have made it necessary for persons operating in educational institutions to achieve graduate preparation. For example, some state boards have listed graduate education requirements for faculty; and accreditation standards have also helped. We do not have the same kinds of motivators in nursing service; and as we have heard, many of the persons now doing heroic jobs in service agencies do not have graduate preparation. And, so their need has been identified, and perhaps is more readily recognized.

The point that it was not necessary for administators to have the same experience as that required by clinical specialists is something that our group addressed and agreed with. On the other hand one must recognize that some persons will become very successful clinical specialists, then subsequently decide that they want to make their contribution in the administration of health services for a particular population of people; for example: administrators in public health agencies or in educational institutions. It might well be that many of our future administrators will be persons who have been clinical specialists and who subsequently take additional preparation or have additional experiences that lead them to positions in administration. I think that many of us have had that kind of experience. I suspect most of us who teach in shcools of nursing or who administer schools of nursing have at one time been teachers of a particular clinical field and similarly, administrators in service agencies have previously been clinical specialists.

The task force members concur with the caucus endorsement of priority attention to graduate programs inasmuch as that seems to be our greatest need at the present time. That is not to deny that nurses should seek opportunities for undergraduate preparation in nursing with an introduction to leadership as an integral part of those programs. Residencies or practicums as program requirements are the prerogative of every higher institution. Whether or not there is consensus about that is something to be worked out by the persons who are offering the programs.

The idea of administration in the historical perspective related to Ms. Martel's presentation of yesterday. She pointed out that last year she might have addressed our topic in a much different way. History is being made rapidly, based on the speed with which change takes place. Thus, the need for preparing for rapid change should be an integral part of all programs.

I think we must emphasize over and over again that MAIN cannot develop an educational program. MAIN is not an educational institution. It can facilitate the offering of the program. Facilitation could include having educators get together with their counterparts in service to determine those parts of an educational program or, perhaps, an entire educational program that is appropriate for preparing future administrators. Certainly the emphasis on preparation for the future is appropriate since society expects educational institutions to take responsibility for the future.

Learning opportunities would be provided for students for which they will be awarded credit in any one of several institutions. Our task force members believe that faculty who teach courses should have their credentials reviewed and approved by the agency that will give credit for those courses.

The task group certainly would endorse the notion of interdisciplinary faculty. We would expect the faculties who teach in these extended campus programs to be well qualified people who are experts in their respective fields. For example, if the topic happened to be Labor Relations, it could be a person who was qualified to teach Labor Relations, Financial Planning, and Mangement, and so on. Some of those people may also be nurses, but undoubtedly not all of them, and therefore, the faculty could represent an interdisciplinary mix.

So far as the talent scouts are concerned, we have already had some. Talent scouting has been on-going for mentors who guide and direct the practicums. Those already selected could form a nucleus. In addition to that, of course, some faculty could be self-selected. Many persons can make themselves available and subsequently their credentials could be reviewed by the respective institutions that would be granting credit. I think there are many ways that talent scouting could be done, including nomination -- I can nominate you or you could nominate yourself, or I could nominate myself. We should exploit all of those approaches. Some concerns were expressed about standardization of a curriculum. But the fact that one says there will be content in the program about labor relations or administrative science does not preclude the revision of that particular content as a consequence of new information, or new knowledge that becomes available as research demonstrates that new knowledge exists. I think it is very useful that the group pointed out criteria for sites to be targeted.

Our task group did not address the question of MAIN's fees. My own reaction is that MAIN is an organization that provides services to its members, and therefore, one of the services to it's members would be brokering service that we talked about earlier. It would facilitate the development of a region-wide program.

I recall very vividly the discussion about vicarious learning that would take place among students and faculty. I think it is a very valuable suggestion that throughout a program of study, opportunities should exist for students to get together with one another and with the faculty who teach in the program. Sustained interaction could be by phone or by other means.

Caucus group D identified regional resources and programs. I can appreciate the observations made that:

1) the information was not always up to date, and

2) the information was not always accurate. It has ever been thus with any kind of a published list of programs. Certainly one that had any hope of effecting a region-wide program would have to be constantly brought up to date.

Also, relative to information about postmaster's study, we do not have such directories. When MAIN was first established one of our goals was to have current information and data available. It is extremely difficult to get information about people and about programs. That sort of information is not consistently available. It was our long range goal that when the United States was replete with regional organizations, (and we hoped all regional organizations would have agency members representing both education and service), networking could be complete across the United States. Then we would have a way to share data made available through MAIN, MARNA, WICHE, SREB, and NECHEN. We are not there yet, but I think it is still a good long range goal. Nursing does not have the data it needs. We simply do not, and we have to work on that.

I was interested in the comment that there might be a list of criteria for selection of mentors:

1) that they would have acceptable academic qualifications. That goes without saying, because they would be screened by any educational institution that offers particular programs.

2) that they would hold faculty appointments. I have a tremendous bias about this. It seems to me that educational institutions grant their symbols of accomplishments (degrees) only if persons teaching are qualified. If externships or residency training programs are required as integral parts of the program, then they ought to be guided and directed by persons who are qualified for and who hold faculty appointments. That is a bias and I label it as such. You may not all agree, but it can be debated.

I think there is no question about the need to market the program. There is a limited number of us who have been privileged to attend what I think has been an excellent program which has provided us an opportunity to share ideas and learn from one another. The notion of marketing is extremely important. First we have to market the availability, and then market the advantages that come from such networking. I am pleased that we have had someone from outside the Midwest region who has had some success in this kind of endeavor. I think we are on our way, but we have not yet achieved success in our networking or in our marketing. We need to have many more agency members. We need to have much more involvement. Each of of you has to be a person who markets.

I believe that the notion of extending educational opportunities to prepare nursing administrators has been endorsed. Under those circumstances, I believe that our staff in MAIN, and persons who have volunteered their services so generously in order to make this program successful, and those who consider this to be a worth-while region-wide endeavor, will certainly have their work cut out for them. It will be hard work, but it will be worth it.

REFERENCES

American Nurses' Association, Characteristics of a professional climate of administration and practice in a nursing department. Statement of the Commission on Nursing Services; Task Force on Nursing Practice Climate--A Professional Model. June Werner, RN, Chairperson; Peggy Cannon, RN; and Virginia Cleland, RN, PhD; 1979.

American Society of Nursing Service Administrators, American Hospital Association, Recognition program for excellence in the field of nursing service administration; Nominee Level, Candidate Level, application forms and criteria, 1980.

American Hospital Association, Guidelines: Role, functions, and qualifications of the nursing service administrator in a health care institution, 1979.

American Society of Nursing Service Administrators, American Hospital Association, Preparation of nurse managers, (Informational Bulletin), 1979.

American Society of Nursing Service Administrators, American Hospital Association, Role of the nursing service administrator with hospital governing boards, medical staff, institutional planning, and cost containment, 1979.

APPENDIX A

The Solution Lies in the Mixing of Resources

Collaboration Programs

designed by

the Staff of

Presbyterian Hospital, Inc.

Oklahoma City, Oklahoma

HOSPITAL MILIEU: A System for Internal Collaboration

1. Team Planning Systems - Multidisciplinary groups gather to identify and recommend implementation of tactics needed to achieve a pre-determined strategy.

2. Joint Committees - Staff from various departments combine efforts to provide programs. For example, educators from throughout the hospital conduct basic and advanced teacher preparation seminars.

3. Liaison System - Directors of Nursing are assigned to Directors in non-nursing hospital departments. By meeting regularly, problems are reduced. Issues requiring the interface of nursing management and other departments are openly discussed.

4. Recreational Festivities - An annual festival for employees from all hospital departments allows for outdoor track relays, fun, food, and informational and game booths.

5. Interdisciplinary Clinical Interfaces - Patient care problems are addressed by teams of professionals representing a variety of disciplines.

We're
Patient
People

Presbyterian hospital
Northeast 13th at Lincoln Boulevard
Oklahoma City, Oklahoma 73104
405/271-5100

PROGRAMS ENHANCING EDUCATION/PRACTICE COLLABORATION

1. Clinical Affiliations - Clinical learning experiences for student nurses are enhanced by the combined efforts of faculty and staff in providing for faculty orientations to the clinical facility, faculty work opportunities, preparation of learning resources for students, teacher training courses for staff nurses, strategic clinical placement, and faculty/staff communication.

2. Joint Appointments - Nursing professionals employed jointly by educational institutions and the hospital integrate theory, research, and practice for students and practicing nurses as well.

3. Nurse Extern Program - Collaborating with faculty from baccalaureate and associate degree nursing programs, nursing staff have written an eight-week summer experiential work program for nursing students who agree to work at the hospital the first year following graduation. The program, which includes 200 hours of clinical experience working one to one with a Registered Nurse preceptor and 50 hours of classroom skills labs, discussions, and group work, has been approved for academic credit by two baccalaureate schools of nursing. Students gain expertise in organizing patient care, developing skills competency, and coping with the problems encountered by nurses.

4. Scholarship Endowment Series - Four scholarships are awarded to baccalaureate nursing students who have demonstrated academic excellence, leadership potential, and commitment to nursing. Monthly scholarly seminars involving faculty, students, deans, and nurse managers create an environment conducive to eeting the needs of the gifted and talented in nursing and enrich the professional lives of the participants.

We're
Patient
People

Presbyterian hospital
Northeast 13th at Lincoln Boulevard
Oklahoma City, Oklahoma 73104
405/271-6100

PROGRAMS ENHANCING EDUCATION/PRACTICE COLLABORATION (cont.)

5. High School Program - Hospital nurse educators and nursing administrators interface with high school science teachers to provide clinical rotations and seminars that present nursing as a science. Scientific, problem-solving approaches to patient care are demonstrated to these outstanding high school students who are planning health-related careers.

6. Brown Bag Lunch Program - This is a key interface between student nurses and experienced nurses. By sharing lunch together on a regular basis, students have an opportunity to ask questions about the work environment and clinical dilemmas they will face. Experienced nurses gain insights from students which enable them to re-examine self and work.

7. Educational Mobility - This program, designed to assist registered nurses returning to school, consists of financial aid, educational counseling, flexible work scheduling, small group support sessions, and challenge exam workshops. Further, hospital staff and schools of nursing jointly plan strategies to meet the needs of the career mobile nurse.

8. Continuing Education Consortium - Hospitals and educational institutions collaborate to plan and provide major continuing education offerings for staff nurses, nurse administrators, and nurse educators.

"ACADEMIC WORK TRANSITIONS"

A Model of Hospital-Based Programming

(Designed by Nancy Eatmon, R.N., M.S.)

Academic Levels	Hospital-Based Programs	Work Roles
M.S.N.	Clinical Education Programs Staff Development Programs Management Training Consultant Training Nursing Research Orientation Teacher Preparation	Nurse Manager/ Educator/ Counselor
Career Laddering B.S.N.	Educational Mobility Career Ladder Loan Clinical Education Programs Nursing Research Staff Development Programs Orientation	Staff Nurse
	NEW GRADUATE	GRADUATE NURSE
Final Year - Nursing Education	Senior Leadership Loan Scholarship Clinical Affiliation Brown Bag Lunches Nursing Research Orientation	Senior Nurse Assistant (Student nurse work title)
First Year - Nursing Education	Extern Program Clinical Affiliation Loan Brown Bag Lunches Nursing Research Orientation	Junior Nurse Assistant (Student nurse work title)
High School and Pre-Nursing Academic Work	Pre-Nursing Course High School Course	Nurse Tech

Hospital-based education programs span the gap between academic levels and corresponding work roles. Students/staff can blend their school and work roles in these programs.

NURSING NETWORK: Collaboration in local, national, and international arenas

Interfacing With the Nursing Community

The purpose is to facilitate communication between Presbyterian Hospital and the nursing community in Oklahoma, particularly in Oklahoma City; to increase the visibility of the institution; to effect changes in policies and legislation affecting nursing; to have input into curriculum design and implementation; to increase credibility in academic communities; to develop a network of support for Presbyterian Hospital; and, to increase awareness of upcoming problems so that we can be pro-active.

Program components include: (1) officers in state and local nursing organizations with attendance and dues supported by the hospital, (2) nurses on key committees in schools (recruitment and retention, admissions, career ladder, and course planning), (3) nurses serving as clinical faculty, (4) nurses lecturing in schools, (5) nurses speaking at key programs, (6) program participants at workshops, (7) the use of nursing faculty as consultants to Presbyterian Hospital, (8) the appointment of nursing faculty to committees at Presbyterian Hospital, and (9) informal use of Presbyterian Hospital's nurse educators as consultants on critical issues in nursing education.

Program participants include nurse educators, faculty, and clinical staff.

Dues to organizations, consultation fees, cost of attendance at meetings, etc., are costs incurred. Revenue can also be generated if schools hire nurses as faculty.

NURSING NETWORK (continued)

1. Key Nursing Organizational Positions for Input: Local and National

   - Chairpersons - key committees, state nurses' associations
   - Lecturers - key workshops
   - Advisory Board and Council positions
   - Patient Advocacy positions with such organizations as the American Cancer Society

Hospitals can support financially, the membership dues and time commitment of staff nurses involved at an in-depth level in organizational life. A mechanism for reporting back and coordinating efforts should be established by nursing administrators.

2. An International Model: International Nurse Exchange Program

This three-month program, designed to exchange nurse managers from two countries, promotes a mentality of cosmopolitanism and fosters creation of innovative strategies for health care delivery. Participants establish a residence and interact in the professional arena of their counterparts.

3. The Hospital-Based Fellowship in Nursing Administration

This twelve-month, hospital-based program provides a post-graduate level adult continuing education program for nurses interested in hospital administration. Nurse experts are facilitated to corporate level team managers/administrators. Experience in risk taking, broader spans of control, delegation of authority and responsibility occur in a setting where coaching and critiquing by mentors and potential role models results in very rapid feedback for the fellow.

We're
Patient
People

NURSING NETWORK (continued)

4. Research Interest Groups

Nurses from four hospitals and a college of nursing meet quarterly to discuss proposals and share information.

APPENDIX B

Commission on Education for Health Administration: Development of the Western Network for Education in Health Administration.

The
Western
Network

FOR EDUCATION IN HEALTH ADMINISTRATION

Executive Summary

History of the Project

In 1975 the Commission on Education for Health Administration put forth several important recommendations for graduate education in health administration. Among these was the creation of a task force -- made up of educators and practitioners -- to plan and implement non-traditional lifelong learning programs for health administrators; the development of centers for faculty study and enrichment; and the combination of resources for increased teaching and research opportunities.

With assistance from the W. K. Kellogg Foundation of Battle Creek, Michigan, a planning committee of academic program directors and professional health care administrators met several times during 1976 and 1977 to review the Commission's recommendations.

The Western Network was thus formed. Its purposes were to identify, build and share the academic and practitioner expertise available to fulfill what was to become the project's mission: to design and implement professional development programs for administrators within a broad spectrum of health care services -- hospitals, long term care facilities, group practice associations, mental health associations, planning agencies and others.

Universities and Organizations Involved

The Western Network is an educational collective representing the faculties of health administration programs at the University of California at Berkeley and Los Angeles, the University of Colorado, the University of Washington and Arizona State University. Each of these universities offers a graduate program which has been accredited by the Accrediting Commission on Education for Health Administration.

For program planning and delivery purposes the Western Network works closely with professional associations representing several sectors of the field. Among these are the Association of Western Hospitals, the Healthcare Financial Management Association, the Medical Group Management Association, the American College of Nursing Home Administrators, the American College of Hospital Administrators, the Western Center for Health Planning and the Association of University Programs in Health Administration.

School of Public Health/Warren Hall/Fourth Floor/University of California, Berkeley 94720
(415) 642-1627/642-0790

The Western Network Steering Committee

David B. Starkweather, Dr.P.H.
Chairman, Western Network
Professor, Administrative Health Sciences
University of California
Berkeley, CA

Thomas W. Bice, Ph.D.
Professor and Director
Graduate Program, Health Services
Administration and Planning
University of Washington
Seattle, WA

Robert A. Boissoneau, Ph.D.
Professor
Center for Health
Services Research
Arizona State University
Tempe, AZ

Mardell E. Brandt
Administrator
La Mesa Convalescent Hospital
La Mesa, CA

Fred E. Graham, II, Ph.D.
Associate Director
Medical Group Management
Association
Denver, CO

Joseph M. Hafey
Executive Director
Western Consortium for
the Health Professions, Inc.
San Francisco, CA

Kathryn E. Johnson
Executive Vice President
Association of Western Hospitals
San Francisco, CA

Bettina Kurowski, D.P.A.
Director, Graduate Program
in Health Administration
University of Colorado
Medical Center
Denver, CO

Stanley J. Matek
Executive Director
Orange County Health Planning Council
Tustin, CA

Dennis D. Pointer, Ph.D.
Director, Program in Health
Services Management
University of California
Los Angeles, CA

Catherine A. Robinson
Executive Director, Western Network
c/o University of California
Berkeley, CA

Steven M. Sundre, Ph.D.
Vice President
Association of University Programs
in Health Administration
Washington, D.C.

John C. McFetridge
Executive Director
Boulder Community Hospital
Boulder, CO

Project Funding

The Western Network is supported by grant funds (60%) and self-generated program revenues (40%). In the past four years, two major grants have been awarded by the W. K. Kellogg Foundation to the Western Consortium for the Health Professions, Inc., on behalf of the Western Network.

As a result of its membership in the Western Consortium, the University of Hawaii graduate program in health services administration is also a member of the Western Network.

Steering Committee

The Western Network is governed by a Steering Committee comprised of thirteen members:

- six academics representing the university graduate programs currently involved in Western Network activities;
- four practitioners representing the fields of group practice, nursing home administration, hospital administration and health planning; and
- three members representing the Association of University Programs in Health Administration, the Western Consortium for the Health Professions, Inc. and the Association of Western Hospitals.

The Committee meets 2-3 times per year for 2-day sessions. The Committee assumes the following functions:

- provides program direction;
- reviews all Western Network educational activities;
- reviews and approves all Western Network fiscal activities and, on behalf of the Consortium, serves as the body accountable to the W. K. Kellogg Foundation for Network fiscal affairs;
- formulates all policies germane to future activities; and
- initiates and maintains productive liaison relationships with regional and national representatives of other health services professional associations.

Members of the Steering Committee are listed on the back of page 1.

Major Project Activities

The following is a partial and brief description of Western Network educational activities.

The Western Network Institute for Health Care Executives

(Academic direction: Western Network campus and practitioner advisory committee members)

The Western Network Institute is a nine-day executive development program sponsored by the Western Network and the Association of Western Hospitals. The conference is held in August on the University of California-Berkeley campus, and draws approximately 40 health care executives each year. The dates for the fourth annual program are August 4-12, 1983.

Trustee Week

(Academic direction: University of Washington)

Trustee Week is a week-long series of educational seminars for hospital governing board members. Each year Trustee Week is offered in the Northwest area; in 1982 it was held in Seattle (March 14-19) and Newport Beach, California (May 10-15). Trustees select a two-day segment and attend only that portion of the program that best suits their educational interests and needs. Average attendance per week-long program is 160.

Health Services Management Assessment Process

(Academic direction: University of California, Los Angeles)

HS-MAP is a comprehensive assessment program designed for institutional executive teams. It is now available for use in hospitals and other organizations by arrangement.

Financial Management and Regulation Game

(Academic direction: University of California, Berkeley)

The FMRG is a strategic financial management simulation for health care instructors, students and managers. Originally designed for graduate education, the simulation has been modified and presented in continuing education programs such as the Western Network Institute and the Annual National Institute of the Healthcare Financial Management Association.

The FMRG is also featured in a national computer competition for health administration students. This play is sponsored by the Western Network and the American College of Hospital Administrators, and culminates at the ACHA Congress on Administration.

In March 1982, the Western Network and the Healthcare Financial Management Association offered a national Faculty Development Institute to train academics and practitioners in the use of the financial game as a learning tool.

Rural Health Audio Tapes
(Academic direction: University of Colorado and Arizona State University)

A series of five audio cassette tapes was developed by the Western Network and the Association of Western Hospitals. The tapes are designed for training programs or individual study and cover recruitment and retention of manpower; laws and regulations; rural hospital-based satellite systems; roles and responsibilities of the hospital trustee; and patient education.

National Sabbatical Center
(Academic direction: Leland Kaiser, Ph.D., University of Colorado and the National Advisory Committee)

The Western Network has designed a national center for the development and implementation of executive sabbaticals. The center will offer individualized learning programs designed through a series of personal interviews and goal setting sessions. Sabbaticals may vary in length, but will generally last four-six weeks.

The Western Network Institute for Nurse Executives
(Academic direction: Dennis Pointer, Ph.D. and Martin B. Ross, Dr.P.H., University of California, Los Angeles, and the National Advisory Committee)

An eight-day program for nursing services administrators has been developed by the Western Network. The second annual program will be held from July 23-30, 1983, at the University of California, Berkeley. The Institute is designed for nurses who hold management positions in hospitals, HMO's, long term care facilities, academic institutions and other health-related organizations.

In addition to these projects the Western Network has developed:

- an educational program for governing board members of group practices. These sessions are presented by the Medical Group Management Association and the Western Network. The University of Washington faculty provide academic direction for the project. The first three-day seminar, "Critical Issues Affecting Board Operations," was held March 26 and 27, 1982, in Seattle.

- faculty and doctoral student exchange programs. To provide opportunities for research, teaching and writing, the Western Network is sponsoring a limited number of exchange programs in the 1982 current academic year.

- a plan and curriculum for a non-traditional master's program for practicing health services administrators. Academic direction for this project is based at Arizona State University.

In addition to these activities, the Western Network has capacity and interest in developing and delivering programming in a variety of areas. A partial list includes health planning and analysis, marketing, quality assurance, long term care administration, governance of medical care institutions, financial management and rural health care.

Further information about the Western Network, its capacity or its programs can be obtained by contacting:

Catherine A. Robinson
Executive Director
Western Network for Education in Health Administration
School of Public Health
Warren Hall/Fourth Floor
University of California
Berkeley, CA 94720
(415)642-1627/0790

ERIC Clearinghouse for
Junior Colleges AUG 29 1986